DISABILITY VERIFICATION FORM
STUDENTS WITH CHRONIC HEALTH CONDITIONS

Access Center
Washington State University
Vancouver
Vancouver, WA 98665-9600
Ph: 360.546.9739
Fax: 360.546.9421
van.access.center@wsu.edu

To ensure the provision of reasonable and appropriate services for students with chronic health conditions, disability statutes require students to provide current and comprehensive documentation of their disability and its impact on activities of daily living, including education.

We ask that you complete the following and return it to the address above. All material will be kept confidential.

Thank you for your assistance in this matter.

Student's Name: _____ WSU ID #: _____

1. Name/Type of Disability/Chronic Health Condition (diagnosis):

2. Please choose one: Temporary ◯ Chronic ◯

   If temporary, estimated time of recovery period:

3. Describe any symptoms or functional limitations imposed by the disability/chronic health condition that may impact the student an academic/campus setting. Please specify limitations for physical activities, including overall stamina. Indication severity of symptoms when appropriate.

4. If this student currently on medication(s), describe any side effects this student experiences from medication(s). Please include time of day this is most likely to occur.

5. (Optional) Please provide your specific recommendations (based upon your assessment, the student's clinical and academic history, and diagnosis) for accommodations that you believe will help equalize the student's ability to access Washington State University Vancouver's programs and services.

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above and that I am a licensed psychologist, neuro-psychologist, psychiatrist, or other relevantly trained medical doctor, or counseling professional with training in the evaluation of chronic health conditions in adolescents and adults.

Signature: _____ Date: _____

Print Name and Title: _____

Area of Specialty: _____

State License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

To be completed by WSU student:

I authorize the certified information in this form to be released to WSU Access Services. I consent to be contacted by WSU Access Services regarding this form.

Printed Name _____

Signature _____ Date _____