Disability Verification Form

Disability Resources and Services (DRS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, as amended (2008). The ADA defines a disability as a physical or mental impairment that **substantially** limits one or more major life activities.

1. The healthcare professional(s) conducting the assessment and/or making the diagnosis must meet Maricopa requirements for documentation. These persons are generally trained, certified, or licensed to diagnose medical conditions. https://district.maricopa.edu/regulations/admin-regs/section-2/2-8
2. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. It is recommended that this form be completed by providing the information in this form.
3. The information you provide will be kept in the student's DRS file where it will be held securely and confidentially.
4. If you have questions regarding this form, please call Disability Resources and Services at the campus where you are registered for services.
5. Important: After documentation is reviewed, Disability Resources and Services will send an email notification to the student's Maricopa email account, (MEID@maricopa.edu), acknowledging receipt of documentation and the student's eligibility status.

We understand if wish to submit a letter instead. The letter **must** be on letterhead**, with date and signature**, and must include the following:

- a diagnostic statement identifying the disability (including the date of the diagnosis)
- current severity/impact of the disability (mild/moderate/severe)
- an assessment of major life activities that are impacted by the disability (e.g., learning, concentration, class attendance, social interactions, reading, walking, etc.)
- specific recommendations for accommodations.

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STUDENT INFORMATION (To be completed by student):

First Name _____ Middle _____ Last _____

Date of Birth _____ MEID_____

Status (check one) ☐ current student ☐ transfer student ☐prospective student

Local phone (_____) - _____ - _____ Cell phone (_____) - _____ - _____

Address _____

_____

If current Maricopa student, email address _____ @maricopa.edu

Other email address _____

DIAGNOSTIC INFORMATION
(Please print legibly)

1.Date of Diagnosis:_____Date of Last Evaluation_____

2. Primary Diagnosis (DSM/ICD codes): _____

3. Secondary Diagnosis (DSM/ICD codes): _____

4. What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

5. Please state the medication or treatment plan the student is currently prescribed:

_____

_____

_____

_____

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6. Major Life Activities Assessment:

Life Activity	Negligible	Moderate	Substantial	Not Sure
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-care	☐	☐	☐	☐
Regular Class Attendance	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Keeping Appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing Internal Distractions	☐	☐	☐	☐
Managing External Distractions	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

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7. In addition to the major life activities that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:

_____

_____

8. Please state specific recommendations regarding academic accommodations for this student:

_____

_____

9. Please add any additional comments that you feel appropriate:

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

(Please sign and date below and completely fill in all other fields using PRINT)

Provider Name _____

Title_____

License or Certificate _____

Address_____

_____

Phone Number _____

Email _____

Provider Signature _____ Date _____