

VERIFICATION OF DISABILITY

Student Name (Please Print): _____ **Last four digits of SSN:** _____

I am requesting academic support services through the Center for Students with Disabilities (CSD) at York College. The City University of New York requires current and comprehensive documentation of my disability. Please respond to the following questions as soon as possible and return to me. I authorize the Center for Students with Disabilities (CSD) at York College to contact you if clarification is needed.

Student's Signature: _____ **Date:** _____

Physician/Provider Name (Please Print): _____

Title: _____

License # _____ **Phone #** _____ **Fax #** _____

Organization & Address: _____

1. **Diagnosis(es)** _____

2. **Level of severity** ☐ **Mild** ☐ **Moderate** ☐ **Severe**

3. **Duration** (*This section must be completely filled out for the student to receive services.*)

☐ **Permanent** Diagnosis date ____/____/____

☐ **Chronic** Diagnosis date ____/____/____ (*Likely to last for duration of college attendance*)

☐ **Temporary** Date disability will end: ____/____/____ (*Accommodations not necessary after this date*)

4. Please list procedures/assessments used to diagnose this student's condition. _____

5. What treatment and/or medications are currently being used? _____

6. What are the functional limitations or symptoms? _____

7. How does this condition (or effects of medication) limit this student's ability to learn or to meet the demands in a university setting? _____

8. **Recommended Accommodation(s) based on diagnosis:** _____

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Provider's Signature: _____ **Date:** _____