DISABILITY VERIFICATION

Kansas State University Polytechnic – Academic and Student Services Office

The student named below may be eligible for services and accommodations offered through the Academic and Student Services Office at Kansas State University Polytechnic. In order to determine eligibility, verification and documentation of the student's disability must clearly demonstrate that he or she has one or more functional limitations in the academic environment. Please note that the determination of actual services and accommodations will be made by the Academic and Student Services Office.

TO BE COMPLETED BY STUDENT :

Last Name: _____ **First Name:** _____

Campus ID #: _____ **Date of Birth:** _____

I authorize the release of the information requested below to the Academic and Student Services Office.

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

TO BE COMPLETED BY A LICENSED PROFESSIONAL:

Diagnosis: _____

Disability is: ☐ Permanent ☐ Temporary & Expected to last

Level of severity: ☐ Mild ☐ Moderate ☐ Severe

Date (s) of diagnosis: _____

Date of last office visit: _____

If applicable, provide relevant background information related to student's history.

_____

_____

_____

If applicable, provide assessment/evaluation scores of all tests administered, including a psycho-educational report.

_____

_____

_____

_____

Current prescribed medications related to disability:

Medications	Dose/Frequency	Effects/Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Functional Impact Assessment. Specify the degree of limitation, if any, that the student currently exhibits within each of the following major areas.

1 = Mild 2 = Moderate 3 = Substantiate

Major Life Activity		Degree of Impact				Major Life Activity		Degree of Impact		
		1.	2.	3.				1.	2.	3.
1.	Caring for Oneself					15.	Learning			
2.	Talking						• Reading			
3.	Hearing						• Writing			
4.	Breathing						• Spelling			
5.	Seeing						• Math Reasoning			
6.	Walking/Standing						• Math Calculating			
7.	Lifting/Carrying						• Processing Speed			
8.	Sitting						• Memorizing			
9.	Performing Manual Task						• Concentrating			
10.	Eating						• Listening			
11.	Social Interacting w/ Others					16.	Working			
12.	Sleeping					17.	Housing & Dining			
13.	Thinking					18.	Other:			
14.	Communicating					19.	Other:			

Substantiate major area(s) marked above by elaborating on the impact it may have on the student's ability to function in a university environment.

_____

_____

_____

_____

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual" as defined by the ADA Amendments Act of 2008 (ADAAA). In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (please print): _____

Signature of Professional:_____

License#: _____ Date: _____

Address: _____

Phone#: _____ Fax#: _____

Return this form to our office as soon as possible so this student may begin participation in our program. Please include any verifying documents from your files.