

University of Nevada, Las Vegas
Disability Resource Center
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www.unlv.edu/drc

Hearing Disability Verification Form

The Disability Resource Center (DRC) provides academic services and accommodations for students with diagnosed disabilities. It is the student's responsibility to provide documentation that identifies a diagnosed disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990.

DRC requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.
- Forms must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay processing and result in follow up contact with the healthcare professional.
- The healthcare provider should attach any reports which provide additional related information (e.g. audiogram). **If a comprehensive diagnostic hearing report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.**
- Please do not provide case notes or rating scales without a narrative that explains the results.
- In addition to the requested information, please attach any other information you think would be relevant to the student's need for academic adjustments.
- Complete the Healthcare Provider Information section on the last page and mail or fax it to the address provided above.
- If you have questions regarding this form, please call the DRC office at 702-895-0866.

**This document was adapted with permission from Office for Disability Services, The Ohio State University.*

STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION
(Print or Type)

Name (Last, First, Middle): _____

Date of Birth: _____ NSHE: _____

Status (check one): Current UNLV student
 Transfer student
 Prospective student

Local phone: (____) - ____ - _____

Cell phone: (____) - ____ - _____

UNLV E-Mail address: _____

Personal E-mail address: _____ (for non-admitted students)

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize DRC to communicate with the named individual or agency identified below to obtain clarification as needed to determine my eligibility for disability services at UNLV. This authorization is valid for 6 months.

Student
Signature _____ Date: _____

Parent Signature
(If student is under 18): _____ Date: _____

DIAGNOSTIC INFORMATION
(Please Print Legibly or Type)

Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.

1. What is the degree of the hearing loss (mild, moderate, severe, profound)? Please include a copy of the most recent audiogram. Please include the date of the assessment.

2. At what age was the diagnosis first made? _____

3. When was your last contact with the student? _____

4. Is the hearing loss expected to remain stable or is it expected to decline? If it is expected to decline/improve? Describe the expected progression.

5. Describe how this hearing disability may affect this student both academically and/or physically (functional limitations).

6. What means of communication has this student used in the past? Also, describe the student's current skill in the use of his/her communication skills.

7. What **suggestions** do you have regarding accommodations and/or auxiliary aids, i.e Assistive Listening Devices (ALDs), notetakers, real time captioning, sign language interpreting, etc. for an academic setting? Also, state your **rationale** for the accommodations and/or auxiliary aids you have recommended.

HEALTHCARE PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____ License or Certification #: _____

Address: _____

Phone Number: (____) - ____ - _____

FAX Number: (____) - ____ - _____

The information you provide will *not* become part of the student's academic records, but it will be kept in the student's file at DRC, where it will be held strictly confidential. Files are purged after 7 years in compliance with state requirements. This form may be released to the student at his/her request.