UNLV | DISABILITY RESOURCE CENTER

University of Nevada, Las Vegas
Disability Resource Center
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Medical/Health Disability Verification Form

To be completed by Treating or Diagnosing Physician

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. **If a comprehensive diagnostic 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 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 diagnosis, date of diagnosis, and last contact with the student?

_____

_____

_____

2. Is the student/patient currently under your care? Yes ☐ No ☐

3. List of current medications, impact, and adverse side effects, if any.

4. Major Life Activities Assessment:

   Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Life Activity	1. Negligible	2- Moderate	3- Substantial	Don't Know
Talking				
Hearing				
Breathing				
Standing				
Caring for Oneself				
Reaching				
Lifting				
Sitting				
Walking				
Seeing				
Writing				
Performing Manual Tasks				
Sleeping				
Learning				
Reading				
Thinking				
Concentrating				
Memorizing				
Interacting with Others				
Other:				
Other:				

5. Describe how this medical condition may result in specific functional limitations in an academic setting.

6. What is the expected duration of this disability?

7. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

_____

_____

_____

_____

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.