DISABILITY VERIFICATION
Physical/Orthopedic & Mobility Disabilities

Please read the following prior to completing this form:

Student Accessibility Services (SAS) at Kent State University provides support services to students with diagnosed disabilities, including physical and orthopedic conditions. To ensure the provision of reasonable and appropriate accommodations for our students, this office requests documentation of the disability from the individual’s diagnosing/current licensed physician or a certified nurse practitioner. This should include information that describes the onset of the disability, its manifestation, and recommendations for accommodation in the collegiate academic setting. This office recommends recent documentation in most cases; however, the need for recent documentation depends on the circumstances of the individual’s disability. For additional information or questions about SAS and/or documentation guidelines please visit: www.kent.edu/sas.

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with Student Accessibility Services. I expressly request that my medical provider disclose full and complete protected medical information for the following listed below.

______________________________  ____________________
Signature of Student              Date

Please provide the following information about (student):

1. Diagnosis: ____________________________________________________________________
   Date of Diagnosis: _________________  Last contact with student: ______________________
   Is the student/patient currently under your care?  _____ YES  _____ NO

2. Describe the functional limitations associated with this disability that are specific to this student/patient: ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

3. Describe the progression of the student’s condition, if applicable: _______________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

4. Describe how this condition substantially limits a major life activity and how it may impact the student’s progress in an academic setting: _______________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________

5. List current medication, dosage, frequency and possible adverse side effects as related to academic performance: _______________________
   ____________________________________________________________________
   ____________________________________________________________________
   ____________________________________________________________________
6. List other treatment(s) the student is receiving to manage his/her disability: ________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

7. List any recommendations for accommodations you have for this student in an academic setting:
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

8. Please describe any specific concerns you may have, or other ways that we may be of further assistance to
   this student/patient: __________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

______________________________________________________________

Healthcare Provider Information

Provider Name and Title: __________________________________________

Provider Signature: _____________________________________________ Date: __________

Street Address: ________________________________________________ City: ______________

State: _________ Zip: _____________ Phone: (______)_____________________

The information you provide in this document is maintained in the office of Student Accessibility Services
at Kent State University according to the guidelines of the Family Educational Rights and Privacy Act
(FERPA).

Please mail or fax this completed form to:

Student Accessibility Services · Kent State University · Ground Floor, DeWeese Center
P.O. Box 5190 · Kent, OH 44242

Phone: (330) 672-3391   Fax: (330) 672-3763   Email: sas@kent.edu