



## Verification of Disability

### Ohio Christian University - AIM (Adult Studies) Program

Student Name: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Date Needed: \_\_\_\_\_

**My signature grants the release of the requested information to Ohio Christian University and permits Ohio Christian University officials to consult with the undersigned, as necessary, for one calendar year from the date indicated below.**

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The above student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodation from the AIM department due to a disability. In order to consider the request, as well as to ensure the provision of appropriate auxiliary aids and services, academic adjustments, or other accommodations, OCU policy requires that a qualified healthcare professional provide current and comprehensive verification of the disability. To be considered current, the healthcare professional's statement must be **within three (3) years** prior to the date of the most recent request of the student. The professional(s) conducting the assessment and rendering the diagnosis must be qualified to do so. A qualified professional includes a licensed school psychologist, licensed psychologist, licensed rehabilitation counselor, speech and language pathologist, physician, or other appropriate medical/healthcare professional.

The documentation and information provided must be comprehensive enough to identify the student's current functional limitations. It should also include information that diagnoses the impairment, indicates the severity and longevity of the impairment, and offers suggestions or recommendations for necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations.

To facilitate the gathering of such critical information, please complete this form, attach to the diagnostic report, and return to:

Ohio Christian University AIM Department

Attn:

1476 Lancaster Pike

Circleville, OH 43113

If you have questions regarding this form, please contact:

1. Diagnosis (include DSM diagnosis code, if applicable):

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2. Date of Diagnosis: \_\_\_\_\_

3. Expected Duration of impairment or disability \_\_\_\_\_

4. Is this student/patient currently under your care? \_\_\_\_\_ Yes \_\_\_\_\_ No

5. What suggestions or recommendations do you have regarding necessary and appropriate auxiliary aids or services, academic adjustments, or other accommodations for this student? (Describe modifications/aids.)

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6. Please attach any psycho-educational testing and/or reports which provide current information related to the student/patient's disability or impairment, or describe any other information relevant to this student's request for academic adjustment, auxiliary aides or services, or other accommodation (e.g., affect of prescribed medications, exacerbating factors, etc.).

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OHIO CHRISTIAN  
UNIVERSITY

Healthcare Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and Title: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_