

**Verification of Disability
For Students at Lakeland University**

Please have your Medical Doctor or your Clinical or Counseling Psychologist complete this form or use it as a basis for their narrative summary

(Student's Name)

(Social Security Number)

is a patient of yours who attends or plans to attend Lakeland University. This student has indicated to the University that he or she has been diagnosed with a disability that substantially interferes with a major life function and plans to request accommodations to equalize his or her educational abilities at the post-secondary level.

The Lakeland University Accommodations Review Committee will use the information you provide, along with other relevant information, in consideration of this student's request for educational accommodations. The information requested here is critical to processing your patient's request for educational accommodations. Incomplete applications cannot be considered by the Accommodations Review Committee. If you have any questions about the information requested or how the information will be used, please contact Karen Eckhardt, the ADA Coordinator, at Lakeland University at 920-565-1043 x2115.

After you complete this form or a narrative summary based on this form, return it to:

Karen Eckhardt
ADA Coordinator
Lakeland University
W3718 South Drive
Plymouth, WI 53073
FAX: 920-565-1068

Thank you.

Diagnostic Information

1. Diagnosis: _____
(If the diagnosis includes a learning disability or ADD/ADHD, provide relevant DSM-IV information.)

2. Level of severity: (Check One) Mild Moderate Severe

3. Date of diagnosis: _____

4. What procedures were used to assess/diagnose? (If the diagnosis is based upon test or assessment scores, provide them here. If the diagnosis is ADD/ADHD, please attach physician's diagnostic report and any concurring psychiatric and psychological evaluations.)

5. Describe the symptoms that meet the criteria for this diagnosis, along with approximate date of onset:

6. Does this student have other accompanying disabilities, such as depression, learning disabilities, obsessive-compulsive disorder, or other chronic medical condition that may affect this condition? (If yes, please attach relevant documentation of accompanying disabilities.)

Educational Information

1. Describe the student's functional limitations in an educational setting:

2. What measures were used to assess current educational functioning?

3. Have you any recommendations to make regarding effective academic accommodations to equalize this student's educational opportunities at the post-secondary level? (Please describe your recommendations for services/accommodations in exam administration, or in-class accommodations.)

Other Information

In addition to the diagnostic report, please attach other information relevant to this student's academic adjustment.

Certifying Authority

Signature: _____

Print name and title: _____

License: _____

Address: _____

Phone: _____ Fax: _____

Date: _____