Verification of Disability Form- Academic/Educational Accommodations
Lakeland University

Student: Please have your medical doctor, clinical/counseling psychologist or other qualified care provider complete this form or use it as the basis for their narrative summary.

(Student's Full Name) (Student's Social Security Number)

Care provider: The above-named student is a patient of yours who attends or plans to attend Lakeland University. The student has indicated to the University that they have been diagnosed with a disability that substantially limits one or more major life functions. The student is requesting accommodations that may serve to mitigate the symptoms of their disability and provide equal access to post-secondary opportunities. The information you provide, along with other relevant information, will assist in the process of considering the student's request for accommodations.

The information requested here is critical for processing your patient's request for accommodations. Incomplete verification or lack of information may result in the accommodation process being delayed or denied. If you have questions about the information requested or how the information will be used, please contact Karen Eckhardt, ADA Coordinator, at 920-565-1021 ext. 2115. Following completion of this form, or a narrative summary based on this form, please return it to:

Karen Eckhardt, ADA Coordinator
Lakeland University
W3718 South Drive
Plymouth, WI 53073
FAX: 920-565-1068 Email: EckhardtKL@lakeland.edu

Diagnostic Information:

DSM-V Diagnosis of ADD/ADHD, or LD must be made by a:

- Ph.D. level Clinical or Counseling Psychologist
- Medical Doctor
- State-licensed and certified School Psychologist (for Educational Diagnosis)

Diagnoses of depression, anxiety and other psychological disorders must be made by a:

- Master's or PhD level Clinical or Counseling Psychologist or Social Worker
- Medical Doctor

Diagnoses of physical or medical conditions that substantially interfere with a major life function must be made by a licensed medical doctor.

The diagnosis must be current, (i.e. within the last three years) unless the Disabilities Office extends the time period or the disability documented is of a permanent and unchanging nature.

1. Diagnosis: _____
   (provide relevant DSM-5 or ICD-10 information)

2. Level of severity: _____ Mild _____ Moderate _____ Severe

3. Date of diagnosis: _____

4. What procedures were used to assess/evaluate/diagnose? If the diagnosis is based upon test or assessment scores, please provide them here or attach the diagnostic evaluator's report.

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, conditions or impairments that may affect this diagnosis?

Educational information:

1. Describe the student's functional limitations in an educational setting as a result of their disability, condition or impairment.

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

3. What recommendations do you have regarding reasonable academic accommodations to equalize this student's educational opportunities at the post-secondary level?

4. Do you have any other relevant information to share regarding this student's request for disability-related accommodations?

Certifying Authority:

Printed Name and Title: _____

Signature: _____

License # and State: _____

Address: _____

_____

Phone: _____ Fax: _____

Date: _____