PARADISE VALLEY COMMUNITY COLLEGE

Disability Resources and Services
18401 North 32nd Street Phoenix, AZ 85032 ● 602-787-7171 ● fax: 602-787-7230
dl-pvc-disability@paradisevalley.edu ● www.paradisevalley.edu/drs

Disability Resources and Services
Verification Form

Disability Resources and Services (DRS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act (ADA) of 1990, and the ADA Amendments Act of 2008. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

DRS requires current and comprehensive documentation in order to determine appropriate services and accommodations. This form 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.

This form is intended to assist in meeting our documentation requirements. However, if not thoroughly completed it may not be sufficient as the sole form of documentation provided. Please refer to the documentation guidelines for comprehensive documentation requirements and additional information.

STUDENT INFORMATION

NAME:_____

SCHOOL ID: _____ **DOB:** _____

HOME PHONE: _____ **CELL PHONE:** _____

EMAIL: _____

I, _____ hereby consent and authorize
(student name)

Disability Resources and Services at Paradise Valley Community College and

_____
(provider)

to release, fax, mail or discuss with each other information related
to my registering for accommodations.

SIGNATURE:_____ DATE:_____

DIAGNOSTIC INFORMATION

To be completed and signed by Provider

1. **DIAGNOSIS** : Please list all relevant diagnoses.

_____

_____

Date of Diagnosis: _____ Date of last clinical contact: _____

EVALUATION

- ☐ Structured or unstructured interview with student.
- ☐ Interviews with other persons.
- ☐ Behavioral observations.
- ☐ Medical evaluation (x-ray, lab work, EKG, etc.)
- ☐ Neuro-psychological testing. Attach documentation.
- ☐ Psycho-educational testing. Attach documentation.
- ☐ Other (please specify):_____

SEVERITY / PROGNOSIS / DURATION:_____

_____

CURRENT MEDICATION / TREATMENT:_____

_____

2. **FUNCTIONAL LIMITATIONS** : *Should be determined WITHOUT consideration of mitigating measures (i.e. medication). If the condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.*

MAJOR LIFE ACTIVITIES	Negligible	Moderate	Substantial	Don't Know
Self Care				
Manual Tasks				
Seeing				
Hearing				
Eating				
Sleeping				
Walking				
Standing				
Lifting				
Bending				
Speaking				
Breathing				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Working				

SYMPTOMS: Please describe the student's symptoms, including side effects of treatment and medication, which may affect the student's academic performance.

_____

_____

_____

ACADEMIC IMPACT	Negligible	Moderate	Substantial	Don't Know
Social Interactions				
Attendance				
Keeping appointments				
Meeting deadlines				
Stress Management				
Managing internal distractions				
Managing external distractions				
Organization				
Cognitive Processing				
Memory				
Processing Speed				
Other:				
Other:				

Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

_____

_____

_____

3. **ACCOMMODATIONS / RECOMMENDATIONS**: Please state any specific recommendations regarding academic accommodations and a rationale as to why these accommodations/adjustments/services are warranted based upon the student's functional limitations.

_____

_____

HEALTHCARE PROVIDER INFORMATION

Provider Signature:_____ Date:_____

Provider Name (Print):_____

Title:_____

License/Certification Number:_____

Address: _____

Phone: _____ Fax: _____

CALL IF QUESTIONS: 602-787-7171

PLACE BUSINESS CARD HERE