GREAT FALLS COLLEGE
MONTANA STATE UNIVERSITY

Disability Services
2100 16th Ave. So.
406-771-4311
FAX: 406-771-4342
gfcmsu.edu

Disability Verification Form

Disability Services provides academic accommodations for students with diagnosed disabilities. The purpose of this form is to assist medical providers in documenting a student's relevant disability information for determining accommodation eligibility. Note: This form serves as one option for providing disability documentation to Disability Services. Other examples of documentation include: a physician's or other healthcare professional's letter on letterhead, a diagnostic report, or an IEP/504 plan. Individual Education Plans (IEPs), Summary of Performance (SOP), and/or Section 504 Plans from K-12 institutions may be submitted, including information to verify a disability, statements regarding current academic barriers, accommodations used in the past, and how a disability impacted a student academically.

Under the ADA of 1990, ADAAA of 2008, and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities may be entitled to reasonable accommodations in order to ensure equal access. A disability is defined as a "physical or mental impairment that substantially limits one or more major life activities." To establish that an individual is qualified, documentation must confirm that a specific disability exists and that the disability requires accommodation. This would include information on onset, longevity, severity of symptoms, functional limitations, and effect of medications or other required treatment. Documentation must also support the request for specific accommodations and academic adjustments.

Please note as you complete this form:

The person completing this form should be a healthcare professional (not a relative) who is either (1) qualified to assess and diagnose the student's condition, and/or (2) is a part of the student's treatment plan for a previously diagnosed condition. These professionals are generally trained, certified, or licensed to diagnose and/or treat medical conditions. Healthcare professional examples include: physicians, psychiatrists, psychologists, therapist, social worker, medical doctor, speech-language pathologist, or audiologist. The qualifying professional must have expertise in the area for which they are rendering a diagnosis, including the differential diagnosis of the documented medical, physical, or psychological condition, and follow established practices in the field.

Please complete all parts of this form as thoroughly as possible. Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process.

We invite you to attach to this form any other documents or information you think would relevant in determining the student's academic accommodations.

The information you provide will be kept in the student's file in the Disability Services office, where it will be held securely and confidentially. This form may be released to the student at the student's request.

Once completed, you may fax it to Disability Services at 406-771-4342 or return this form to the student so that they may take this to the Disability Services office at Great Falls College MSU.

If you have any questions regarding this form, please call Disability Services at 406-771-4311.

Student Information

(Please Print Legibly or Type)

First Name:_____ Middle Initial:_____ Last Name: _____

Date of Birth: _____

Status (check one)

☐ Current Student ☐ Transfer Student ☐ Prospective Student

Phone: _____

Address: _____

City: _____

State _____

Zip: _____

Diagnostic Information

(Please print legibly or type)

Date of Diagnosis: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

What is the severity of the disorder?

☐ Mild ☐ Moderate ☐ Severe

Please state the medication or treatment the student is currently prescribed which causes side effects (impacts the student in the educational environment):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Does this condition significantly limit one or more of the following life activities? Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Attending Class				
Breathing				
Calculating				
Caring for Oneself				
Communicating				
Concentrating				
Eating				
Hearing				
Interacting with Others				
Learning				
Lifting/Carrying				
Making/Keeping Appointments				
Managing Distractions				
Meeting Deadlines				
Memorizing				
Organization				
Performing Manual Tasks				
Reaching				
Reading				
Seeing				
Sitting				
Sleeping				
Spelling				
Stress Management				
Taking Exams				
Talking				
Thinking				
Walking/Standing				
Working				
Writing				
Other				

For those major life activities checked above, please provide an explanation of the impact of the limitation (e.g. degree of significance, how it affects the student in a learning environment).

_____

_____

_____

_____

_____

_____

_____

_____

_____

What specific academic accommodations would you recommend for this student?
Please add any additional comments you feel appropriate:

Healthcare Provider Information

(Please sign and date below and completely fill in all other fields using PRINT or TYPE)

Provider Signature: _____

Provider's Name (printed) and Title: _____

Street Address: _____

City, State, Zip: _____

Date: _____

License or Certification Number: _____

Phone: _____ Fax: _____

Updated: 7-19