ROO WELLNESS
ACCESSIBILITY SERVICES

5110 Oak St., Brookside 51, Suite 224, Kansas City, MO 64112
(816) 235-5612 (816) 235-6363 accessibility@umkc.edu www.umkc.edu/wellness

1. **This form must be completed by a qualified professional not related to the student** (e.g. physician, psychiatrist, psychologist, counselor, speech-language pathologist, etc.).

2. **All sections of the disability verification form must be completed**. Missing information may result in the delay or rejection of the request for accommodation. Where appropriate, summary and data from specific test results should be attached. If a comprehensive diagnostic report is available that provides the requested information it can be submitted in lieu of the disability verification form.

Please contact Student Accessibility Services at (816) 235-5612 if you have any questions. Thank you for your assistance.

STUDENT INFORMATION
(To be completed by student)

First Name: _____ Last Name: _____

Student ID #_____ DOB: _____

Phone: (_____) _____ Email: _____

I authorize the following individual or organization to release the information included in this document to

Student Accessibility Services at the University of Missouri-Kansas City:

Evaluator's Name/Title: _____ Phone: (_____) _____

Address: _____

City: _____State: _____ Zip: _____

Signature: _____ Date_____
(If under 18 must be signed by parent or guardian)

DIAGNOSTIC INFORMATION
(To be completed by qualified evaluator)

1. Please state the specific diagnosis.

_____

_____

If applicable, please rate the level of severity of the student's diagnosis.

Mild ☐ Moderate ☐ Severe ☐

Duration of condition: ☐ Permanent ☐ Temporary (specify length of time) _____

Date of Diagnosis: _____ Date of last contact with student: _____

2. How did you arrive at your diagnosis? Please circle all relevant items below. If applicable, please attach the diagnostic reports and/or test results administered to determine diagnosis.

Behavioral Observations

Neuro-Psychological Testing,

Development History

Date(s) of Testing _____

Medical History

Psycho-Educational Testing,

Date(s) of Testing _____

Rating Scales

Structured/Unstructured Interview

Other (Please specify):

_____

_____

3. Please indicate the level of impact the student's disability may have in limiting the following major life activities:

Life Activity	No Impact	Negligible Impact	Moderate Impact	Substantial Impact	N/A
Attending class regularly					
Caring for oneself					
Communicating					
Concentrating					
Hearing					
Interacting with others					
Interacting with a group					
Learning					
Making/keeping appointments					
Managing distractions					
Managing stress					
Meeting deadlines					
Memorizing					
Organization					
Performing manual tasks					
Reading					
Seeing					
Sleeping					
Thinking					
Writing					
Other:					

4. For the major life activities checked on the opposite page, please provide an explanation of the functional impact in an academic setting.

5. If applicable, please describe the relevant history of remediation (e.g. current medications, side effects of medications, other treatment plans and their effectiveness).

6. Please list any recommendations for accommodations you have for this student in an academic setting, if applicable. (Please note, recommendations will be considered in the interactive process, however final decisions will be determined by SAS staff.)

7. Please provide any additional information that you think would be useful to know in working with this student.

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature: _____ Date: _____

Title: _____

License or Certification # _____ National Provider Identifier (NPI): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Please attach a business card or provide a facsimile.

Please mail, fax or email this completed form to:

Student Accessibility Services · University of Missouri - Kansas City · 5110 Oak St · Kansas City, MO 64112

Phone: (816) 235-5612 · **Fax:** (816) 235-6363 · **Email:** accessibility@umkc.edu