

## DISABILITY VERIFICATION FORM

This form must be completed by a licensed healthcare or qualified professional and returned to the Disability Services Office. Documentation is kept confidential and separate from academic records per Section 504 of the Rehabilitation Act and the ADA (2008).

### SECTION A — ACCOMMODATION TYPE (check all that apply)

- Academic / Course Accommodations  Housing / Residential Accommodations

### SECTION B — STUDENT INFORMATION (completed by student)

Student Name: \_\_\_\_\_ Catawba ID #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Catawba Email: \_\_\_\_\_  
Expected Grad. Year: \_\_\_\_\_ Academic Year Needed: \_\_\_\_\_  
 Freshman  Sophomore  Junior  Senior  Graduate

### SECTION C — EVALUATING PROVIDER INFORMATION (completed by provider)

Provider Name: \_\_\_\_\_ License / Credential #: \_\_\_\_\_  
Specialty / Title: \_\_\_\_\_ State of Licensure: \_\_\_\_\_  
Practice / Institution: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City / State / ZIP: \_\_\_\_\_ Date of Evaluation: \_\_\_\_\_

### SECTION D — DIAGNOSIS & FUNCTIONAL IMPACT

Primary Diagnosis: \_\_\_\_\_ ICD-10 / DSM Code: \_\_\_\_\_  
Secondary Diagnosis (if any): \_\_\_\_\_ ICD-10 / DSM Code: \_\_\_\_\_  
Disability Category (check all that apply):  
 Physical / Mobility  Learning Disability  
 Chronic Health / Medical  ADHD / ADD  
 Sensory – Vision  Autism Spectrum  
 Sensory – Hearing  Temporary / Injury-Related  
 Psychological / Mental Health  Other (describe below)  
 Neurological

Describe how this disability substantially limits one or more major life activities and its expected duration:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SECTION E — ACADEMIC ACCOMMODATION RECOMMENDATIONS (complete if applicable)

Please note: Provider recommendations will be carefully considered during the interactive accommodations process but are not guaranteed. Final accommodation determinations are made by the Disability Services Office in accordance with applicable law and institutional policy.

Describe recommended academic accommodations and their clinical basis:

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## SECTION F — HOUSING ACCOMMODATION RECOMMENDATIONS (complete if applicable)

Please note: Provider recommendations will be carefully considered during the interactive accommodations process but are not guaranteed. Final housing accommodation determinations are made by the Disability Services Office in collaboration with Housing & Residence Life, in accordance with applicable law and institutional policy.

Describe recommended housing accommodations and their medical / clinical necessity:

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## SECTION G — SUPPORTING DETAILS

Date Documentation  
Prepared: \_\_\_\_\_

Documentation Valid  
Through: \_\_\_\_\_

Yes — permanent / ongoing

No — temporary condition

Expected duration (if temporary): \_\_\_\_\_

Has the student previously received accommodations?

Yes

No

Any additional clinical observations or recommendations relevant to accommodations:

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## SECTION H — PROVIDER CERTIFICATION & SIGNATURE

I certify that I am a licensed professional qualified to diagnose and evaluate the condition described above, that I have a treating relationship with the named student, and that the information provided is accurate and current. I understand this documentation will be used solely to determine reasonable accommodations at Catawba College.

Provider Signature

Printed Name

Date

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Return completed form to: Disability Services Office | [disabilityservices@catawba.edu](mailto:disabilityservices@catawba.edu) | [catawba.edu/disabilityservices](http://catawba.edu/disabilityservices) For questions call the Disability Services Office, M–F 8am–5pm. Documentation is confidential and maintained separately from academic records.