Rock Valley College

Disability Support Services
3301 N. Mulford Road
Rockford, IL 61114-2379

Phone: (815) 921-2371
Fax: (815) 921-2379

# Disability Verification form

Disability Support Services (DSS) 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.

Please take note of the following as you complete this form:

A. The person completing this form should be a healthcare professional 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. Examples include: psychiatrist, psychologist, therapist, social worker, medical doctor, optometrist, speech-language pathologist.

B. Please complete all parts of this form as thoroughly as possible. Inadequate information, illegible handwriting, or missing fields may delay the eligibility review process by necessitating follow up contact for clarification.

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

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

Once completed, please email this form to RVC-DisabilityServices@rockvalleycollege.edu or fax it to 815-921-2379. If you have questions regarding this form, please call Disability Support Services at 815-921-2371

Thank you for your assistance.

Rock Valley College

## STUDENT INFORMATION

**First Name** _____ **Middle**_____**Last** _____

**Date of Birth** _____ **Cell Phone (**_____**) -**_____**-**_____

## DIAGNOSTIC INFORMATION

**(Please print legibly or type)**

| Primary Diagnosis | Diagnosis | Date of Diagnosis | Severity of Diagnosis | | |
|---|---|---|---|---|---|
| | | | Mild | Moderate | Severe |
| Primary Diagnosis | | | ☐ | ☐ | ☐ |
| Other Diagnosis | | | ☐ | ☐ | ☐ |
| Other Diagnosis | | | ☐ | ☐ | ☐ |
| Other Diagnosis | | | ☐ | ☐ | ☐ |
| Other Diagnosis | | | ☐ | ☐ | ☐ |

1. Please state the medication or treatment the student is currently prescribed for EACH diagnosis and any notable side effects that may impact their academic performance:

Rock Valley College

2. Please describe **in detail** any functional limitations associated with the student's disability:

3. Please explain the expected stability of fluctuation for EACH diagnosis (example: stability, frequency, duration of episodes, expected changes over time, etc.)

4. Please state specific recommendations regarding academic accommodations for this student:

Rock Valley College

## HEALTHCARE PROVIDER INFORMATION

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

**Provider Signature**_____ **Date**_____

**Provider Name (print)**_____

**Title**_____

**License or Certification #** _____

**Address** _____

_____

_____

**Phone Number** (_____) -_____-_____

**Fax Number** (_____) -_____-_____

**Email** _____