# DISABILITY VERIFICATION FORM TO BE COMPLETED BY HEALTHCARE PROVIDER

Dear Healthcare Provider:

To ensure the provision of reasonable and appropriate accommodations for WSU students, please provide current and comprehensive documentation of their disability and its impact on their major life activities, including their education.

We ask that you accurately and completely fill out this disability verification form and return it either via mail, fax, or email:

Student Accommodations and Disability Resources c/o Matthew Jeffries

Washington Building, Room 217

PO Box 642322 / Pullman, WA 99164-2322

Phone: 509.335.3417 / Fax: 509.335.8511

accommodations@wsu.edu

All material will be kept confidential in accordance with applicable laws. Thank you for your assistance in this matter. If you have questions, please contact Student Accommodations and Disability Resources by email: accommodations@wsu.edu

This form is to be completed by the healthcare provider.

Student’s Full Name: DOB: WSU ID Number:

Identify Diagnosis of Current Disability and/or Health Condition:

1. Please state the following:
   1. Diagnosis:
   2. Date of diagnosis:
   3. How the diagnosis was made (e.g., ancillary studies, testing, evaluations, etc.):
   4. Status of condition(s) (e.g., active, progressing, controlled, in remission):
   5. Current level of severity (choose one): Mild Moderate Severe
   6. Who diagnosed this condition and their full name, professional credentials, and address:
2. Please choose one:

|  |  |
| --- | --- |
| Temporary |  |
| Permanent |  |

* 1. If temporary, estimated time of recovery period:

3. Describe in detail any symptoms or functional limitations caused by the disability, (medical or mental health condition) including how it affects major life activities such as described below. Please also indicate severity of symptoms when appropriate.

|  |  |  |  |
| --- | --- | --- | --- |
| Inability to concentrate/focus |  | Compromised executive function (self-regulation/organization/time management |  |
| Inability to sleep |  | Slow processing speed (reading/writing/math calculations) |  |
| Inability to control urination/bowels |  | Inability to think clearly/function when condition is active |  |
| Inability to type/write |  | Inability to learn |  |
| Inability to reduce stress |  | Inability to walk |  |
| Easily distracted in the classroom |  | Inability to see/hear |  |
| Inability to attend class on a regular, predictable basis |  | Other |  |
| Difficulty breathing |  |  |  |

4. What exacerbates this student’s specific disability(ies)?

5. Please describe how this disability affects their academic performance, including clinical requirements (if applicable), or their ability to participate in campus activities.

6. If this student is currently on medication(s), describe any side effects this student experiences from medication(s). Please include the time of day this is most likely to occur.

(Optional) Please provide your specific recommendations (based upon your assessment, the student’s clinical and academic history, and diagnosis) for accommodations that you believe will help equalize the student’s ability to access Washington State University's programs and services.

Suggested recommendations for accommodations may include:

|  |  |
| --- | --- |
| Extended time for exams |  |
| Reduced distraction environment for exams |  |
| Ability to leave class to take care of healthcare needs |  |
| Notetaker/Scribe |  |
| Housing accommodations (air conditioner, refrigerator, dietary modifications, emotional support animal) |  |
| Flexibility with attendance |  |
| CAT Van Transportation (through WSU Transportation Services) |  |
| Other |  |

I certify under penalty of perjury, by my signature below, that I completed this disability verification form truthfully and accurately. I represent and warrant that I personally evaluated and/or supervised the evaluation of the student above in accordance with the law and professional standards and the diagnosis of the student’s medical or mental health condition is based upon my professional opinion and clinical judgement. I also represent and warrant that my evaluation and diagnosis of the student’s medical or mental health condition is within the scope of my practice and professional license.

Date:

Signature:

Print Name and Title:

Area of Specialty and Credential:

State License:

License Number:

Please identify if your license is in good standing, you are subject to discipline, or subject to an investigation by any state licensing board:

Office Address:

Office Phone Number:

Fax Number:

*Last revised October 2025*