Rock Valley College

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 at their request.

Once completed, please email RVC-DisabilityServices@rockvalleycollege.edu with the form or give it to the student to return to us. If you have questions regarding this form, please call Disability Support Services at (815) 921-2371.

Thank you for your assistance.

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Student Information

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____ Cell Phone Number: _____

Diagnostic Information

Please print legibly or type.

Diagnosis	**Date of Diagnosis**	**Severity of Diagnosis (Mild, Moderate, or 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:

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.)

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

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 Number: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email Address: _____