University of Alaska Disability Verification Form

The student listed below requested academic accommodations at the University of Alaska. Comprehensive documentation that establishes the diagnosis and describes the impact on major life activities, particularly learning, concentrating and student life, is required.

This form should be completed by an appropriate licensed professional such as the diagnosing physician, licensed healthcare provider, psychiatrist, psychologist, or clinical social worker.

Student completes this section:

Name (please print):_____ Date: _____

Student Signature: _____ UA Student ID:_____

By signing above I consent to releasing the following information to the University of Alaska Disability Services Offices.

Professional completes this section:

1. **Diagnosis(es):**

   _____

   _____

   _____

   _____

   Overall level of limitation: _____

2. **History of diagnosis(es):** Date of diagnosis: _____

   Length and type of treatment:

   _____

   _____

   _____

   Describe symptoms that meet criteria for this diagnosis(es) and approximate date of onset:

   _____

   _____

   _____

   Will the student require hospitalization or in-patient treatment for this diagnosis? If so, list approximate dates and length of stay:

   _____

   _____

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3. **Describe the student's functional limitation(s),** and degree to which functioning is impaired. Please include information about the impact of medication side effects, if relevant:

_____

_____

_____

_____

_____

4. **Duration:** ☐Permanent (longer than 6 months) ☐Temporary – End Date: _____

5. **Other impacts** or information helpful in determining accommodations in an educational setting:

_____

_____

_____

***Please attach any additional relevant information to explain the impact of this student's condition on functioning, such as diagnostic reports, etc.**

I understand that the information provided in this form may become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request. I verify that the above information is complete and accurate to the best of my knowledge and certify that I am not related to this student.

Printed name of provider completing this form: _____

Signature:_____Date: _____

Clinical Specialty:_____License: _____

Phone: _____ Fax: _____ E-mail: _____

Address: _____

Street/PO City State Zip

University of Alaska Disability Services Offices

Please return this form to the student or to your local UA Disability Services at:

UAF Disability Services
PO Box 755590
Fairbanks, AK 99775
Phone. (907) 474-5655
Fax. (907) 474-5688
e-mail: uaf-disability-services@alaska.edu

UAA Disability Support Services
3211 Providence Dr., Room RH-112
Anchorage, AK 99508
Phone. (907) 786-4530
Fax. (907) 786-4531
e-mail: uaa_dss@alaska.edu

UAS Disability Services
11066 Auke Lake Way
Mailstop: MO1
Juneau, AK 99801
Phone. (907) 796-6000
Fax. (907) 796-6005
e-mail: uas.disabilityservices@alaska.edu