

DISABLED STUDENT SERVICES
Montana State University in Bozeman
Strand Union Building 155
Bozeman, MT 59717-3960

Voice: (406)994-2824
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TTY: (406)994-6701

DISABILITY VERIFICATION (PHYSICAL & PSYCHOLOGICAL)

The student named below may be eligible for services offered through this office. In order to provide these services, we must have verification of the student's disability.

Please note: The determination of actual services and accommodations will be made by Disabled Student Services.

To be completed by STUDENT (please print legibly in ink):

Student's Name: _____
Last First Middle

Address: _____

Phone #: _____

Social Security #: _____ Date of Birth: _____

I authorize the release of information requested below to Disabled Student Services at Montana State University at Bozeman. (Your evaluator may have additional releases for you to sign).

Student's Release Signature Date

To be completed by a licensed/certified PROFESSIONAL:

1). Diagnosis: _____

2). This disability is: _____ permanent _____ temporary and expected to last _____

3). Level of severity: _____ Mild _____ Moderate _____ Severe _____ Partial Remission

4). Date(s) of diagnosis: _____

5). Date of last office visit: _____

6). For a **MOBILITY LIMITATION**:

Is this student a wheelchair user? _____ No _____ Yes

Without **significant** fatigue, injury or pain:

Can he/she climb steps or sharp inclines? _____ No _____ Yes; if yes, how many? _____

Recommended accommodations: _____

7). For a **VISUAL IMPAIRMENT**:

Visual acuity: Left: _____ Right: _____ Field: Left: _____ Right: _____

Recommended accommodations: _____

8). For a **HEARING IMPAIRMENT** (please include a recent audiogram):

DB Loss: _____ Left _____ Right

Recommended accommodations: _____

9). How does the student's disability substantially limit his/her ability to function in an academic environment (i.e., mobility, classroom activities, test taking, etc.):

10). Recommended accommodations for all other disabilities: _____

11). Current prescribed medications related to disability:

Medication	Effects/side effects
_____	_____
_____	_____
_____	_____

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (please print): _____

Signature of Professional: _____

License/certification #: _____ Date: _____

Address: _____

Phone #: _____ Fax #: _____

Return this form to our office as soon as possible so this student may begin participation in our program. Please include any verifying documents from your files.