

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

Voice: (406)994-2824
Fax: (406)994-3943
TTY: (406)994-6701

DISABILITY VERIFICATION

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). Multiaxial DSM-IV classification(s): _____

3). Level of severity: ____Mild ____Moderate ____Severe ____Partial Remission

4). Date(s) of diagnosis: _____

5). Date of last office visit: _____

6). Assessment/evaluation procedures. **Attach standard scores (age-based of all tests administered. LD & AD/HD disabilities must supply a full and recent report:**

7). Relevant background information (i.e., history of disability). **LD/ADHD may leave blank if this information is included within attached report:**

8). How does the student's disability **substantially limit** his/her ability to function in an academic environment (i.e., mobility, classroom activities, test taking, memory or perception, etc. * not paying attention or boredom are NOT acceptable examples of substantial limitations on functioning):

9). Current prescribed medications related to disability:

Medication

Effects/side effects

_____	_____
_____	_____
_____	_____

I certify that the above referenced client/patient has a "physical or mental impairment the 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.