

# Disability Verification Form



ROCKY MOUNTAIN COLLEGE

The student named below is eligible for academic support services provided by Disability Services (DSS) at Rocky Mountain College. The office of Disability Support Services requires documentation of a student's disability. Your prompt return of this form will help ensure that this student receives appropriate support services.

STUDENTS NAME: \_\_\_\_\_

Last four digits of SS# \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

I authorize the release of information requested below to Disability Support Services at Rocky Mountain College.

Student's Release Signature \_\_\_\_\_ Date \_\_\_\_\_

## TO BE COMPLETED BY A LICENSED/CERTIFIED PROFESSIONAL

1. Diagnosis \_\_\_\_\_
2. Disability is:  Permanent  Temporary
3. Level of Severity:  Mild  Moderate  Severe  Partial  Remission
4. Date(s) of diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_ 5. Date of last office Visit \_\_\_\_/\_\_\_\_/\_\_\_\_
6. How does the disability substantially limit the student's ability to function in an academic environment:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Currently prescribed medication related to disability:  

Medication	Effects/Side Effects
_____	_____
_____	_____
_____	_____
8. For a mobility limitation: Does the student use a wheelchair? Yes No
9. For a visual impairment: Visual Activity: Left \_\_\_\_\_ Field: Left \_\_\_\_\_  
Right \_\_\_\_\_ Right \_\_\_\_\_

Recommended Accommodations for Specific Disability:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I certify that the above referenced client/patient has a disability that "substantially limits one or more major life activities of such individual" as defined by the Americans with Disabilities Act. I also certify that I possess the necessary professional qualifications to document the client's/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional: PRINTED \_\_\_\_\_ Title: \_\_\_\_\_

Signature of Professional: \_\_\_\_\_

License/Certification #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Thank you! Return to:

Terri Haun, Disability Support Services, Rocky Mountain College, 1511 Poly Dr., Billings, MT 59102

Or Fax to: (406) 657-1037