Disability Services (DS) – LA 104
4800 East Huron River Drive
Ann Arbor, Michigan 48105

Tel: (734) 973-3342
Fax: (734) 477-8517
www.wccnet.edu

Disability Verification

The student named below may be eligible for services offered through the Disability Services Office. In order to provide these services, verification of the student's disability is required. Please note: The determination of actual services and accommodation will be made by the Disability Services Office (DS).

Student's Name: ____
Last First MI

WCC
ID Number: @____________________ Date of Birth: ___________________________

I authorize the release of the information requested below to the Disability Services Office (DS) at Washtenaw Community College.

____ ______________________
Student's Signature Date

To be completed by a licensed PROFESSIONAL:

1. Diagnosis:____
2. DSM-5 or ICD-10 diagnostic code(s):____
   ____
   ____
   ____
3. Level of severity: Mild _____ Moderate _____ Severe _____ Partial Remission _____
4. Date of diagnosis: ____
5. Date of last office visit:____
6. Assessment/evaluation procedures. Attach scores of all tests administered. (If available, please include a psychoeducational report):
   ____
   ____
   ____
   ____
   ____
   ____
   ____

Please continue on second page

Student's Name: ____________________________________

7. Relevant background information:
____
____
____
____

8. How does the student's disability affect his/her ability to function in an academic environment (e.g. mobility, classroom activities, test taking, memory or perception, etc.)?
____
____
____
____

9. Current prescribed medications related to disability (mitigating the effects of the disability and/or causing side effects related to student's educational functioning):

Medication	Dose/Frequency	Effects/Side Effects
_______________	___________________	__________________
_______________	___________________	__________________
_______________	___________________	__________________
_______________	___________________	__________________

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the 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 #: ____
Date: ____
Address: ____
____

Phone and FAX: ____

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