Disability Verification Form

*** Please make sure the relevant Disability Verification Form(s) are filled out.**
- Deaf/Hard of Hearing or Blind/Low Vision
- Learning Disability, Autism, ADD/ADHD, Speech/Communication
- Medical Conditions
- Mental Health

The purpose of this Disability Verification Form is to provide the Office of Special Services (SPSV) with information regarding the current impact of the student's disability. This information will assist SPSV staff in determining whether reasonable accommodations are appropriate in the academic setting, as requested by the student. For questions or assistance, please contact our office at 718-997-5780 or email qc.spsv@qc.cuny.edu.

Under Family Educational Rights and Privacy Act (FERPA) and the Americans with Disabilities Act (ADA), a student's disability and accommodation records are confidential and only shared as permitted by law or with the student's written consent. Before completing this form, both the student and their healthcare provider should review what information is being released, why, and to whom. Healthcare providers must also complete their own HIPAA release form prior to sending the relevant documents to our office if requested.

Under ADA, a diagnosis is classified as a disability only if it **substantially limits at least one major life activity**. Simply having a diagnosis is not enough to be considered a disability or to qualify for accommodations.

The qualified professional should complete this form only for the diagnosis(es) they are licensed to diagnose and treat.

*** Reasonable accommodations do not** alter the essential nature of a course or program, compromise academic integrity, create an undue burden on the college, or serve as a personal service.
Additionally, it's important to remember that accommodations are provided to ensure equal educational opportunities, **not to** guarantee success. Ultimately, the responsibility for success rests with the student.

- The Office of Special Services, August 2025

Learning Disability, Autism, ADD/ADHD, Speech/Communication

* This form must be submitted to SPSV within 6 months of the evaluation date. If a testing like **psychoeducational or neuropsychological evaluation** was completed within the past 3 year for students, this form is optional but highly recommended.

Date of Evaluation: _____

Please provide the patient's diagnosis(es) according to DSM-V criteria and check all relevant boxes.

Diagnosis:_____ **Diagnosis Date:** _____

Current severity of diagnosis: ☐ Mild ☐ Moderate ☐ Substantial ☐ Severe

Symptoms that are substantial:	**Symptoms that are not substantial:**

Prognosis of diagnosis: ☐ Favorable ☐ Stable ☐ Poor ☐ Uncertain:_____

Expected Length (Specify to best of knowledge):

☐ Temporary/Short Term (< 6 mths): _____ ☐ Long/Chronic (6+ mths): _____

☐ Permanent ☐ Episodic/Infrequent:_____

Is reevaluation needed? ☐ No ☐ Yes: _____

Diagnosis:_____ **Diagnosis Date:** _____

Current severity of diagnosis: ☐ Mild ☐ Moderate ☐ Substantial ☐ Severe

Symptoms that are substantial:	**Symptoms that are not substantial:**

Prognosis of diagnosis: ☐ Favorable ☐ Stable ☐ Poor ☐ Uncertain: _____

Expected Length (Specify to best of knowledge):

☐ Temporary/Short Term (< 6 mths): _____ ☐ Long/Chronic (6+ mths): _____

☐ Permanent ☐ Episodic/Infrequent: _____

Is reevaluation for symptoms or diagnosis needed? ☐ No ☐ Yes: _____

Please check all current testing diagnostics used to arrive at your diagnosis. Please submit all evaluations that are non-medical records along with this form.

☐ Medical Records ☐ Standardized Testing (Test name & Date)

☐ Psychoeducational Testing (Most recent date) ☐ Neuropsychological Testing (Most recent date)

Please provide a detailed explanation of how the diagnosis(es) directly and substantially impact the patient's major life activity(ies) and current overall functional limitations. Functional limitations may include, but are not limited to, mobility, vision, and cognitive functioning. N/A if not applicable.

Please explain the medication and treatments (psychotherapy, etc.) the patient is currently on, the history of the plans, and how it currently affects the patient. Please make sure to include the medication's dosage strength, frequency, schedule/time interval, and side effects experienced if applicable. N/A if not applicable.

Are there any stressors/triggers that exacerbate the patient's condition? If yes, please describe the specific stressors/triggers, how the patient manages the resulting symptoms, and the approximate amount of time it takes for the patient to return to their prior level of functioning. Additional important diagnosis(es) that are not substantially limiting may be listed here for overall understanding of the student's history. N/A if not applicable.

Please provide a detailed explanation of how the current diagnosis(es) directly impact the patient's classroom environment. Recommended accommodations will be taken as suggestions. Mark as N/A if not applicable.
* Accommodations must provide a clear, direct and reasonable benefit to the student by addressing the documented substantially limiting impairment that affects at least one major life activity.

Please provide a detailed explanation of how the current diagnosis(es) directly impact the patient's testing environment. Recommended accommodations will be taken as suggestions. Mark as N/A if not applicable.
* Accommodations must provide a clear, direct and reasonable benefit to the student by addressing the documented substantially limiting impairment that affects at least one major life activity.

Please provide additional comments if needed. N/A if not applicable.

By signing below, I am confirming that I have no conflict of interest with my patient. The patient is not a relative to me by blood or through marriage and there is no relationship between both parties other than patient and healthcare provider. The evaluation regarding the student's diagnosis is accurate to my knowledge as a qualified licensed healthcare provider who can diagnose and treat the student's stated diagnosis.

Name of medical or mental health professional: _____

Professional Credential: _____

License #: _____

State licensed to practice and country: _____

Address: _____

Telephone: _____

Signature: _____ **Date**: _____