Disability Support Services

University Campus College of Education Rm 135 1500 University Dr. Billings, MT 59101 (406) 657-2283 FAX (406) 657-1658

City College Tech. Building, Rm 016A 3803 Central Av. Billings, MT 59102 (406)247-3029 FAX (406) 247-3014



Video Phone (406) 545-2518

Disability Verif	fication							
The student named below has identified you as a licensed professional who is familiar with								
him/her. Please assist us in providing appropriate educational services for this student by verifying								
his/her diagnosis (diagnoses). In addition, please tell us how the student's disability may affect								
his/her ability to	function	n in an acade	emic env	ironment :	and any ac	commodati	ons that	you believe
will assist the stu					,			
Release of info	rmation,	to be com	pleted b	y the stuc	lent (please	print legibly	in ink):	
Student's Name:		•	-	•	-		ŕ	
Student's Name:	Last		, F	First	Mid	dle	Date o	of Birth
I Authorize the	release	of information	tion reg	uested be	low to Dis	sability Sur	port Se	rvices at
Montana State			-			• •	-	
		, 8	`	,			J	0 /
Student's Rele	ease Signatu	ıre					D	ate
Student's Rele	ease Signatu	nre					D	ate
			rtified p	profession	al (Please us	se additional p		
Student's Relation			rtified p	orofession	al (Please us	se additional p		
			rtified p	profession	al (Please us	se additional _I		
To be complete 1. Diagnoses:	ed by a l		rtified p	orofession	al (Please us	se additional p		
To be complete 1. Diagnoses: 3. Level of	ed by a l	icensed/ce					oages as n	eeded)
To be complete 1. Diagnoses:	ed by a l		rtified p	Partial Remission		se additional p	oages as n	eeded)
To be complete 1. Diagnoses: 3. Level of	ed by a l	icensed/ce		□ Partial			oages as n	eeded) □ Partial
To be complete 1. Diagnoses: 3. Level of Severity:	ed by a l	icensed/ce		□ Partial			oages as n	eeded) □ Partial
To be complete 1. Diagnoses: 3. Level of Severity: 4. Dates of	ed by a l	icensed/ce		□ Partial			oages as n	eeded) □ Partial

Please help Disability Support Services at MSUB and City College to provide the most helpful and effective educational environment for your client/patient. Take a few moments to consider and answer the following two questions. We value your knowledge of this student and will seriously consider the information you provide in developing the individual accommodations that will give this student access to the programs and services of MSUB and City College.

6. How do the student's disabilities limit his/her ability to function in an academic environment? 7. What are some accommodations that will help the student with tasks such as reading, taking tests, paying attention in class, note taking, etc.? Please include a psychological evaluation or psycho-educational evaluation for LD & AD/HD if available. The report should include the following: Assessment/evaluation procedures along with scores of all tests administered. Relevant background information (i.e., history of disability). 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 Date Professional Credential_ License/Certification # Street Address City State Zip Please return this form as soon as possible so this student may receive accommodations. Please include the necessary verifying documents from your files.

To be completed by a licensed/certified professional (continued)