

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

Disability Verification

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 in an academic environment and any accommodations that you believe will assist the student in the tasks of learning.

Release of information, to be completed by the student (please print legibly in ink):

Student's Name: _____ , _____
Last First Middle Date of Birth

I Authorize the release of information requested below to Disability Support Services at Montana State University Billings. (Your evaluator may have additional releases for you to sign.)

 Student's Release Signature

 Date

To be completed by a licensed/certified professional (Please use additional pages as needed)

1. Diagnoses:		
2. Duration	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Expected duration of temporary disability: _____	<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary Expected duration of temporary disability: _____
3. Level of Severity:	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Partial Remission	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Partial Remission
4. Dates of Diagnoses:		
5. Dates of last office visits:		

Mobility Limitation

6. Does the student use a wheelchair? No Yes, Powered Yes, Non-powered Other: _____

Mobility Limitation (continued)

Recommended accommodations:

Visual Impairment

Left

Right

7. Diagnoses:

a. Acuity

b. Field

Recommended accommodations:

Hearing Impairment: Please include a current audiological report.

Left

Right

8. Diagnoses:

a. DB Loss

b. Hearing Aids

9. Ability to Sign?

Expert	Good	Fair	Poor	None	I don't know
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Recommended accommodations:

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

10. How does the student's disability substantially limit his/her ability to function in an academic environment (i.e. mobility, attendance, classroom activities, test taking, etc.)?

11. Suggested accommodations:

12. Additional comments:

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.