DISABILITY SUPPORT SERVICES
MONTANA STATE UNIVERSITY BILLINGS

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

**City College**
**Tech. Building, Rm 016A**
**3803 Central Ave**
**Billings, MT 59102**
**PHONE 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: | | |
| 3. Level of Severity: | ☐ Mild ☐ Moderate ☐ Severe ☐ Partial Remission | ☐ Mild ☐ Moderate ☐ Severe ☐ Partial Remission |
| 4. Dates of Diagnoses: | | |
| 5. Dates of last office visits: | | |

**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.**