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	☐ Permanent ☐ Temporary	☐ Permanent ☐ Temporary
	Expected duration of temporary disability. _____	Expected duration of temporary disability. _____
3. Level of Severity:	☐ Mild ☐ Moderate ☐ Severe ☐ Partial Remission	☐ Mild ☐ Moderate ☐ Severe ☐ 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

Recommended accommodations:

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.