Abilities Office of Student Services
9501 South King Drive CRSU #190
Chicago, Illinois 60628-1598

Verification of Disability

In order to establish that a student is an "otherwise qualified student with a disability," the Abilities Office of Disabled Student Services (AO) of Chicago State University, in accordance with the Americans with Disabilities Act of 1990 (ADA) and Section 504 of the Rehabilitation Act of 1973 (504), is requesting documentation of a disability. This student has requested services related to his/her disability from AO and has stated that you are an appropriate individual to provide this disability documentation.

Directions: This form is to be completed by a **licensed professional or certified diagnostician.** Please complete this form in order to document that this student does indeed have a disability that substantially limits learning and/or some other major life activity. Please thoroughly answer all questions in as much detail as possible, as this will provide the Abilities Office with information that is needed to advocate for this student.

Student's First & Last Name: _____

2. **What is the diagnosis/impairment?** (Include DSM classifications, if appropriate.)

   Dx:_____

3. Tests

8. **Recommendations:** Please recommend accommodation(s) which may assist the student in performing academic requirements.

9. **History:** Please provide any chronological information which may be relevant to this student's disability.

10. **Comments:** Any additional information that can assist in providing appropriate services for this student.

_____ _____

Provider's Signature Date

Print Provider's Name_____ Title/License#: _____

Provider's Address: _____

Provider's Phone: _____ Fax: _____

After completing this form, please return it to the Abilities Office at the above address or fax it to 773-995-3563. Please contact Nicole Mathews, Assistant Director of Abilities at 773-995-2380 if you have questions about this form.

Student Release of Medical Information

I authorize my physician or professional clinician to release information pertaining to my diagnosis to the Abilities Office of Student Services at Chicago State University, for the purpose of supporting my request for accommodations due to my disability.

Student Signature Date

Witness Date