Services for Students with Disabilities
Verification Form for Students with Temporary Disabilities

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the “Guidelines for Documenting Autism Spectrum Disorders” for comprehensive documentation requirements and additional information. To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current (within the last 3 years) documentation of the disability. This documentation should provide information regarding the onset, longevity and severity of symptoms, as well as the specifics describing how it has interfered with educational achievement. Please include a copy (including test scores) of any relevant psychoeducational or neuropsychological reports. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact SDS at (919) 530-6325 with questions.

The information below is to be completed and signed by the student.
I request and authorize North Carolina Central University, Office of Student Disability Services and/or my off-campus provider
(name)________________________________________ to release, fax, mail or discuss with each other information related to my registering with Student Disability Services (SDS).

________________________________________
Student Name

________________________________________
Student Signature

Email Address: ____________________________ Phone Number: ____________________________

Date

If the information above is left blank or is incomplete it may delay or prevent SSD from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.
1. Please list all Diagnoses (name and at least one code):

Diagnoses:

1. _______________________________   ________   ________
2. _______________________________   ________   ________
3. _______________________________   ________   ________
4. _______________________________   ________   ________
5. _______________________________   ________   ________

a. Date diagnosed: __________ / __________ / __________

b. Approximate duration of diagnosis, injury, and/or condition
   • 2 weeks or less
   • 2-4 weeks
   • 4-8 weeks
   • 8-12 weeks
   • Unknown (please explain): __________________________________________

2. Functional Limitations: Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

   a. Does this condition significantly limit one or more of the following major life activities?

<table>
<thead>
<tr>
<th></th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Substantial Impact</th>
<th>Don't Know</th>
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</thead>
<tbody>
<tr>
<td>Communicating</td>
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<tr>
<td>Concentrating</td>
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<td>Hearing</td>
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<td>Learning</td>
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<td>Manual Tasks</td>
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<td>Reading</td>
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<td>Seeing</td>
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<td>Thinking</td>
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</table>
b. Please check the **functional limitations or behavioral manifestations** for this student:

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<tr>
<th></th>
<th>Not an Issue</th>
<th>Moderate Issue</th>
<th>Substantial Issue</th>
<th>Don't Know</th>
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<tbody>
<tr>
<td>Cognitive Processing</td>
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<td>Memory</td>
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<td>Processing Speed</td>
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<tr>
<td>Meeting Deadlines</td>
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<tr>
<td>Attending class</td>
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<td>Organization</td>
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<td>Reasoning</td>
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<td>Stress</td>
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<td>Sleep</td>
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<td>Appetite</td>
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<td>Other:</td>
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<td>Other:</td>
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</table>

4. **Accommodations**

a. Please mark whether student has utilized accommodations in the past.
   - Yes- Please describe:__________________________________________________
   - No
   - Don't Know

b. (Optional) Recommended educational accommodations:
________________________________________________________________________
________________________________________________________________________

   c. (Optional) Please provide any additional information you feel will be useful in determining the nature and severity of the student’s disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions:
________________________________________________________________________
________________________________________________________________________
Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document. All documentation submitted to SDS is considered confidential.

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**Provider Information**

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: ___________________________ Date: _______________________

Print Name and Title: _______________________________________________________

State of License: ______ License Number: _________________________________

Address: ________________________________________________________________

Street or P.O. Box: ___________________________ City: ______ State: ______ Zip: ______

Phone: ___________________________ Fax: ______________________________

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All documentation is confidential and should be submitted to:

**North Carolina Central University**  
1801 Fayetteville Street  
Suite 120 Student Services Building  
Durham, NC 27707  
Attention: Director of Student Disability Services