University of Idaho
Center for Disability
Access and Resources

VERIFICATION/AUTHORIZATION FORM FOR STUDENTS WITH DISABILITIES

Student/Patient: Date of Birth:

Authorization for Release of Information By signing below, I hereby voluntarily request and authorize the physician, counselor, psychologist, psychiatrist, audiologist, social worker or other licensed professional appropriately qualified to diagnose the specific disability of the individual listed on this form to furnish and/or discuss with University of Idaho's Center for Disability Access and Resources any information, including medical or healthcare information in their possession that may help the University of Idaho verify and evaluation my request for accommodation under the Americans with disability Act (ADA). This may include a diagnosis and/or description of associated functional limitations and capabilities, as well as any information related to previous or current recommended accommodations, academic adjustments, or other work on my behalf. I understand that this release will remain in effect unless revoked by me in writing directed to CDAR.

Student Signature: _____ Date: _____

Date of last clinical contact with student:

DSM-5 or ICD-10 Diagnosis

Diagnosis	Level of Severity (mild to severe)	Age of Onset	Temporary or Permanent? If temporary, what is the expected duration?
1.			
2.			
3.			
4.			
5.			

Functional Limitations

Does this condition **significantly limit one or more of the following major life activities**? Check all that apply and **check level of impact** (moderate or severe):

☐ **Communicating** (☐ moderate or ☐ severe) ☐ **Learning** (☐ moderate or ☐ severe) ☐ **Hearing** (☐ moderate ☐ severe)

☐ **Concentrating** (☐ moderate or ☐ severe) ☐ **Working** (☐ moderate or ☐ severe) ☐ **Reading** (☐ moderate ☐ severe)

☐ **Manual Tasks** (☐ moderate or ☐ severe) ☐ **Seeing** (☐ moderate or ☐ severe) ☐ **Thinking** (☐ moderate ☐ severe)

☐ **Walking** (☐ moderate or ☐ severe) ☐ **Other:** (☐ moderate or ☐ severe)

Academic Concerns

Check all that apply and check degree of issue (moderate or substantial)

☐ **Cognitive Processing** (☐ moderate or ☐ substantial)
☐ **Processing Speed** (☐ moderate or ☐ substantial)
☐ **Attending Class** (☐ moderate or ☐ substantial)
☐ **Reasoning** (☐ moderate or ☐ substantial)
☐ **Sleep** (☐ moderate or ☐ substantial)
☐ **Other** (☐ moderate or ☐ substantial)

☐ **Memory** (☐ moderate or ☐ substantial)
☐ **Meeting Deadlines** (☐ moderate or ☐ substantial)
☐ **Organization** (☐ moderate or ☐ substantial)
☐ **Stress** (☐ moderate or ☐ substantial)
☐ **Appetite** (☐ moderate or ☐ substantial)

Please describe how the disability/medical condition impacts the student in an academic setting:

If the condition includes any unpredicted, episodic flare-ups, please describe the frequency, severity, and duration:

If applicable, please describe any side effects or negative impact due to the current medication:

Please include any additional information that will assist us in determining accommodations that will provide access to an academic environment:

Provider Details/Signature

Provider Name: Title: Agency:

Address: Phone:

Credentials:

Signature: Date: