



**Disability Verification Form  
(To Be Completed by a Qualified Professional Provider)**

The University of New Haven is committed to providing equal educational opportunities for students with disabilities and encourages them to request support services under laws such as the Americans with Disabilities Act Amendment Act (ADAAA) and Section 504 of the Rehabilitation Act and to establish the need for reasonable accommodations. Disability is defined as a physical or mental impairment that substantially limits one or more major life activities.

The Accessibility Resources Center (ARC) is dedicated to assisting qualified students by offering appropriate accommodations to facilitate access to educational opportunities. However, it is important to note that these accommodations cannot fundamentally alter the nature or requirements of courses.

The provision of “all reasonable accommodations” is based on the current impact of the disability on academic performance. Thorough documentation significantly assists with the determination of appropriate reasonable accommodations that the student is qualified to receive, therefore it is in the student's best interest to provide recent and appropriate documentation

**To consider this request, the Accessibility Resources Center (ARC) requires that this form be completed by a qualified professional who has firsthand knowledge of the student's condition and is an impartial individual unrelated to the student.**

Student: \_\_\_\_\_ Date of Completion of Form: \_\_\_\_\_

Name of Certifying Professional: \_\_\_\_\_

Name of Agency: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Professional Title: \_\_\_\_\_

License/Certification Number and Issuing State: \_\_\_\_\_

## Diagnostic Assessment

***Please attach a copy of any diagnostic report, psychoeducational or neuropsychological evaluation that can be used in being prescriptive in assigning accommodations for this individual.***

**Disability Diagnosis:** \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Date of Last Contact with Student: \_\_\_\_\_

How would you categorize this condition?

- ☐ Stable
- ☐ Episodic in nature (please consider this when indicting impact, see chart on page 3)
- ☐ Prone to exacerbation (please consider this when indicating impact, see chart on page 3)

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Duration of the impairment is:

- ☐ Permanent
- ☐ Temporary: Provide expected duration **OR** re-evaluation date: \_\_\_\_\_

If applicable, indicate any currently prescribed medication side effects which may impact the student's functioning in an academic setting.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please feel free to provide any additional relevant history, psychosocial, or contextual factors:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Impact of Condition on Educational Success

***Does this condition significantly limit one or more of the following major life activities?*** Functional Limitations on major life activities should be determined WITHOUT consideration of mitigating measures (i.e. medication, eyeglasses, hearing aids, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms. Please indicate any mitigating measures and their impact under COMMENTS if impact is different when mitigated.

Life Activity	Mild	Moderate	Substantial	NA	Comments – Please Explain
Operation of a major bodily function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Performing manual tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lifting/Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Remembering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Communicating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Caring for oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Interacting with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other(indicate): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

***Educational and Behavioral Interventions:***

Please describe academic interventions, coaching support or other behavioral programs that have been made available and their level of effectiveness for this student: \_\_\_\_\_

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**Suggested Accommodations**

Your recommendations can be helpful in our assessment of need and/or appropriate accommodations. Each suggested accommodation should be accompanied by an explanation of its relevance to the functional limitations of the diagnosed disability specified on Page 3 above, as well as how it specifically impacts this student's academic abilities.

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If other treatments are currently mitigating the limitations of the student's impairment, please provide rationale for the further accommodations.

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Discuss the potential impact on your client if the suggested accommodation(s) cannot be granted.

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## Signature of Certifying Professional

**NOTE:** *Final determination of appropriate accommodations will be conducted by the Accessibility Resources Center in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act, as amended, as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.*

You are completing this form for the student named above who has indicated that they have a disability or medical condition and will require reasonable accommodation(s) to participate in a program or activity at the University of New Haven. In order for the university to proceed, we may require additional information after reviewing the information provided in this document. The student understands that the Accessibility Resources Center staff or a designee may request additional information after reviewing this document and upon submission of their application.

Please list the best times to contact you:

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**\*I certify, by my signature below that this information is true, accurate, and complete.**

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Signature of Certifying Professional

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Date

**This document may not be released without the student's written permission, except as permitted by the Family Educational Rights and Privacy Act (FERPA). FERPA allows disclosure to university staff or faculty with a legitimate educational interest and grants the student the right to access this document.**

### *Thank you for your assistance in completing this form*

If you have any questions regarding the nature of this information needed for students with disabilities, please call the Accessibility Resources Center at (203) 932-7332, Mon. through Fri. from 8:30 A.M. to 4:30 P.M.

**This form and any supplemental documentation can be submitted to Accessibility Resources Center at [arc@newhaven.edu](mailto:arc@newhaven.edu), or via fax (203) 931-6082, or send via mail to:**

University of New Haven  
Accessibility Resources Center  
300 Boston Post Road  
West Haven, CT 06516