DISABILITY VERIFICATION
To Be Completed and Signed by a Qualified Licensed Professional
(*-Indicates Required Information)
(-Indicates Required Information, if applicable)**

*Name: _____ *SS/ID#_____

*Date of Verification: _____ *Verified By: _____

*Date Diagnosed: _____ *By Whom: _____

**DSM IV Diagnosis: _____

**Physical Diagnosis: _____

**Learning Diagnosis: _____

***Major Life Activity** with which this condition interferes:
__ Manual tasks ___Walking __Seeing __Hearing __Breathing ___Learning ___Speaking

Functional Limitation

_____Organizing/Sequencing
_____Easily Distracted
_____Poor Concentration
_____Difficulty Focusing for Extended Periods of Time
_____Difficulty Formulating and Executing Plan of Action
____Abstract Thinking
____Panic Attacks
____Other: (Be Specific)

Recommended Accommodations:

_____
_____
_____

_____ _____
***Physician's Signature** ***Date**

_____
***Physician's Printed Name**

_____
***Address, City, State, Zip**

_____
Physician's Email Address

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