THE UNIVERSITY OF ALABAMA® | Office for Academic Affairs
Disability Services

Disability Verification Form for Providers

Dear Healthcare Professional,

The University of Alabama's Office of Disability Services (ODS) determines academic accommodations for students with diagnosed disabilities. This form helps healthcare providers document a student's disability to determine accommodation eligibility.

- A qualified professional with considerable knowledge of the student's condition must complete the attached form, demonstrating how the disability significantly limits major life activities.
- Previous educational records and documentation from family members is considered supplemental.
- Information provided is confidential under the Family Educational Rights and Privacy Act (FERPA) but may be released to the student upon request.
- Avoid restating the student's self-report (i.e., "student reports" or "student endorses"). ODS requires objective evidence of substantial limitations.
- A single diagnostic encounter is typically insufficient to establish a non-observable disability or need for accommodations. ODS may request additional information if necessary.
- Incomplete, illegible, or missing information will delay the eligibility review. ODS may request more details. Using the fillable PDF form with typed responses is recommended.
- Providers may attach additional supportive documentation on letterhead.

The legal definition of disability is a mental or physical condition that substantially limits a major life activity compared to most people. Substantial in this context means a notable, significant, meaningful limit/difference to how the individual engages in the activity, the conditions necessary for them to engage in the activity, the duration for which they can engage in the activity, or the frequency which they engage in the activity.

Major life activities include but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, speaking, breathing, learning, reading, concentrating, communicating, and the proper functioning of major bodily systems.

Student Name: _____

Student CWID: _____ Student Date of Birth: _____

I. HISTORICAL INFORMATION

Is the student currently under your care? No☐ Yes ☐

How long has the student been in your care? _____

When did you last see the student? _____

Date of onset of symptoms: _____

List the student's presenting symptoms:

Provide any relevant developmental/educational/medical history.

II. DIAGNOSIS

What is the student's **primary** diagnosis based on the DSM or ICD? Please include diagnostic code. You may include secondary diagnoses on page 6.

_____

List and describe the diagnostic criteria endorsed.

List the objective measures used to help substantiate the diagnosis.

Provide explanation or evidence that other possible explanations have been investigated and ruled out.

III. EVIDENCE OF IMPAIRMENT

Provide results from objective measures and your interpretation of the results, demonstrating how the student is substantially limited beyond the experience of the general population:

List the symptoms that substantially limit the student's ability to perform major life activities. Avoid listing generally symptoms associated with the condition; information must be current and specific to the student's experience.

Symptom	Frequency (daily, weekly, monthly)	Severity (mild, moderate, severe)	Duration (in length)

What are the functional limitations of the **primary** diagnosis? Please identify functional limitations without regard for mitigating measures (i.e., medications). For intermittent conditions, assess functional limitations based on a picture when all symptoms are active. Complete the table on the following page, using an "X" to indicate the level of impact on major life activities.

Major Life Activities	No Impact	Mildly Impacts	Moderately Impacts	Substantially Impacts	Unknown
Bodily regulation	☐	☐	☐	☐	☐
Breathing	☐	☐	☐	☐	☐
Caring for oneself	☐	☐	☐	☐	☐
Communicating	☐	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	☐
Learning	☐	☐	☐	☐	☐
Maintaining consciousness	☐	☐	☐	☐	☐
Performing manual tasks	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Wakefulness or alertness	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Other:					

List and describe the specific functional limitations resulting from the disability's impact on the major life activities in a learning environment (e.g. unable to traverse stairs, missing class due to side effects from disability or medication, unable to sit for long periods, etc.).

Are the functional limitations permanent? No ☐ Yes ☐

If not, what is the anticipated date of resolution? _____

SUMMARY

Provide any additional information that may be relevant to the student in an academic setting:

Healthcare Provider Information:

First and Last Name: _____

Title/Credentials/Area of Specialty:

Date: _____

Provider Signature: _____

Please return this information by email to ods@ua.edu, fax to (205)348-0804, or mail to The Office of Disability Services, 1000 Houser Hall, Box 870185, Tuscaloosa, AL 35487. Call (205)348-4285 with questions.

Revised December 2024

IF APPLICABLE, PROVIDE ADDITIONAL DISABILITY DIAGNOSES BELOW.

I. HISTORICAL INFORMATION

Date of onset of symptoms of **secondary** diagnosis: _____

List the student's presenting symptoms related to the **secondary** diagnosis:

Provide any relevant developmental/educational/medical history. If there is no additional information to add, use N/A.

II. DIAGNOSIS

What is the student's **secondary** diagnosis based on the DSM or ICD? Please include diagnostic code. _____

List and describe the diagnostic criteria endorsed.

List the objective measures used to help substantiate the **secondary** diagnosis.

Provide explanation or evidence that other possible explanations have been investigated and ruled out.

III. EVIDENCE OF IMPAIRMENT

Provide results from objective measures and your interpretation of the results, demonstrating how the student is substantially limited beyond the experience of the general population:

List the symptoms of the **secondary** diagnosis that substantially limit the student's ability to perform major life activities. Avoid listing generally symptoms associated with the condition; information must be current and specific to the student's experience.

Symptom	Frequency (daily, weekly, monthly)	Severity (mild, moderate, severe)	Duration (in length)

What are the functional limitations of the **secondary** diagnosis? Please identify functional limitations without regard for mitigating measures (i.e., medications). For intermittent conditions, assess functional limitations based on a picture when all symptoms are active. Complete the table below using an "X" to indicate the level of impact on major life activities.

Major Life Activities	No Impact	Mildly Impacts	Moderately Impacts	Substantially Impacts	Unknown
Bodily regulation	☐	☐	☐	☐	☐
Breathing	☐	☐	☐	☐	☐
Caring for oneself	☐	☐	☐	☐	☐
Communicating	☐	☐	☐	☐	☐
Concentrating	☐	☐	☐	☐	☐
Eating	☐	☐	☐	☐	☐

	No Impact	Mildly Impacts	Moderately Impacts	Substantially Impacts	Unknown
Hearing	☐	☐	☐	☐	☐
Learning	☐	☐	☐	☐	☐
Maintaining consciousness	☐	☐	☐	☐	☐
Performing manual tasks	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Seeing	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐
Speaking	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐
Wakefulness or alertness	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐
Other:					

List and describe the specific functional limitations resulting from the **secondary** disability's impact on the major life activities in a learning environment (e.g. unable to traverse stairs, missing class due to side effects from disability or medication, unable to sit for long periods, etc.).

Are the functional limitations permanent? No ☐ Yes ☐

If not, what is the anticipated date of resolution? _____