Medical Disability Verification Form

The student named below has applied for academic accommodations through Disability Services at USC Upstate. In order to determine eligibility, we require current and comprehensive documentation of the student’s disability.

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please return it to the student or, with the student’s permission, you may return it to our office. The information you provide will be held confidential and will not become part of the student’s educational records. In addition to the requested information, please attach any reports which provide additional related information. Please contact us at 864/503-5199 or email Disability Services at DSINFO@uscupstate.edu if you have any questions or concerns. Thank you for your assistance.

Consent For External Release of Information

I, _____________________________, authorize ________________________________to release to Disability Services at the University of South Carolina Upstate any and all information that is relevant to my disability, the functional limitations imposed by my disability and any recommendations of possible accommodations including, but not limited to, the information in the attached form.

Student Signature: ___________________________________________ Date: __________________________
1. Student’s Name (Last, First, Middle):

2. What is the student’s primary diagnosis?

3. Date of Diagnosis: _____/_____/_______  Date of Initial Diagnosis: _____/_____/_______
   Approximate date of onset: _____/_____/_______

4. Date student was last seen: _____/_____/_______

5. What is the severity of the disorder? _____ Mild  _____ Moderate  _____ Severe
   Please describe the severity checked above:

6. List current medications, impact, and side effects:

7. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically:

8. Please check which of the major life activities listed below are significantly affected as a result of his/her medical condition. Please indicate the level of limitation.

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<thead>
<tr>
<th>Life Activity</th>
<th>No Impact</th>
<th>Moderate Impact</th>
<th>Severe Impact</th>
<th>Don’t Know</th>
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<tbody>
<tr>
<td>Caring for Oneself</td>
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<td>Performing Manual Tasks</td>
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</table>
9. State the student’s functional limitations (challenges for academics arising from the condition) based on the medical diagnosis, specifically in a post-secondary environment:
________________________________________________________________________________________
________________________________________________________________________________________

10. Please state specific recommendations regarding academic accommodations for this student and provide your rationale for these recommendations.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

11. Is there anything else you think we should know about this student?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

12. Describe any referrals for additional medical testing/evaluation for this student:
________________________________________________________________________________________
________________________________________________________________________________________

Certifying Professional:

Signature of Professional

Date

Professional’s Name (Printed) and Title

Name of Practice

Professional Credentials

License or Certification No.

Address

Telephone No.

City, State, Zip

Fax

Disability Services
Division of Student Affairs
University of South Carolina Upstate
800 University Way, CLC 107, Spartanburg, SC 29303
Fax to 864-347-3328 or email to Disability Services at DSINFO@uscupstate.edu.

Revised 2/21/2019