DISABILITY VERIFICATION

The student named below may be eligible for accommodations at Florida A & M University. In order to provide services we must have verification of disability. It is understood that information on this form is provided with a written release from the below named student (see attached page) and will be used in confidence for the educational benefit of the student.

First Name          Middle Initial          Last Name

1. Description of disability(ies) and date of diagnosis(es): ____________________________________________
   ____________________________________________
   ____________________________________________

2. Description/Severity of functional limitations (i.e. limited ambulation; visual acuity; degree of hearing loss, etc.) ____________________________________________
   ____________________________________________

3. Prescribed medications and dosage: ____________________________________________
   ____________________________________________

4. The above mentioned disability(ies) is/are: _______ permanent/chronic
   _______ temporary (until what date__________)?

5. What assistance or accommodations would help this student in an academic setting?
   ____________________________________________
   ____________________________________________

6. This disability is: □ observable □ not observable

7. The information contained in this verification □ may be released to the student
   □ may not be released to the student

Certifying Professional:

Name (typed or printed)    Signature
Title    License #
Address   City    State    Zip Code
Phone (_____)    Date