Longwood University
Office of Disability Resources
Verification of Disability

DEFINITION: This form is provided for purposes of assuring nondiscrimination against individuals with disabilities. Under the Americans with Disabilities Act. A disability is an impairment that substantially limits a major life activity, which is an everyday activity a person can perform with little or no difficulty. Incomplete forms may cause a delay in providing services. Failure to complete this form may delay student services

NOTE: This form may not be used to supplement documentation of ADD/ADHD.

This form is to be completed by the current treating professional (e.g. physician, psychologist) of the Longwood student.

Name of student:_____

1. Diagnosis of primary disability. Please include /ICD-9 or DSM-IV Code.

   Date first diagnosed:

2. Functional Limitations: What difficulty does the student experience due to this condition? (e.g. limited ambulation, poor visual acuity, degree of hearing loss)

3. Does this student's condition *substantially* limit a major life activity when compared to the average person? _____ Yes _____ NO
   If yes, what activities are significantly limited?

4. Current Treatment(s)/Therapy and Prescribed Medications and Dosages:

5. The disability above is:
   { } Permanent/Chronic
   { } Long Tern/6-12 months
   { } Short Term/Temporary, 6 months or less (expected duration: _____)

6. The disability is:
   { } Observable { }Not Observable

7. Please use the space below (and additional sheets as needed) to provide any information that will be helpful to University staff in considering the necessary accommodations. You may choose to address these questions:
   a. Is impact of the condition life threatening if certain accommodations are not provided?
   b. Is there a negative health impact that may be permanent if an accommodation is not provided?
   c. Is an accommodation request an integral component of a treatment plan for the condition in question?

8. What accommodations do you recommend for University consideration?

I certify that this student is currently under my care.

Signature:_____ Date:_____

Name Please print):_____

Title:_____

Name of Agency:_____

Phone Number:_____ Fax Number:_____

Street Address:_____

City/State/Zip Code:_____

Please return to:
Office of Disability Resources
Longwood University
Graham Hall
201 W. High Street
Farmville, VA 23909

Phone: (434)395-2391
Fax: (434) 395-2434

"To request the information provided in this document in an alternate format contact the Office of Disability Resources at 434-395-4935(TRS 711)".