Disability Verification Form

The Office of Disability Services (ODS) at Southern New Hampshire University (SNHU) facilitates academic, physical, and programmatic services and accommodations for students with documented disabilities. Accommodations are determined on a case-by-case basis based on a review of the documentation provided and an intake meeting with a Disability Specialist. The documentation provided should:

- Be recent.
- Establish the disability and date of diagnosis.
- Be completed by a diagnosing or treating health care professional.
- Explain the current impact of the disability in a college environment, and support the need for the requested accommodations requested.

Although the Office of Disability Services will review and consider all documentation submitted, ODS will make the final determination of whether reasonable accommodations are substantiated and can be provided to the individual. If the documentation submitted does not support the need for the requested accommodations, further documentation may be required.

There are several ways to provide ODS with documentation of a disability including:

- **A detailed evaluation or diagnostic report and plan.** Typically these reports will include information on the student’s levels of aptitude, achievement, and information processing. These reports are recommended for students with Learning Disabilities, ADD/ADHD, and Autism Spectrum Disorder.
- **A plan that provides proof of prior accommodations.** This may also include documentation that illustrates any past use of accommodations.
- **Completion of SNHU's Disability Verification Form (pages 2-4)** by an appropriate health care professional.
- **A letter from a health care professional.** This information should be provided on letterhead with the date and signature and provide the following information:
  - Disability and date of diagnosis.
  - Severity of the impact of the disability (mild, moderate, severe).
  - An assessment of major life activities that are impacted (for example: concentration, memory, social interactions, learning).
  - Recommended accommodations.
  - Include test scores when applicable.

Office of Disability Services
2500 North River Road
Manchester, NH 03106
Phone: 603.644.3118, Fax: 603.644.3132

12/2016
Disability Verification Form
(Please type or print clearly)

Student’s Name________________________________________

Date of Birth:_________________ Student ID:______________________________

Address: ________________________________________________________________

________________________________________________________________________

Email: _________________________ Cell Phone: ______________Other Phone: __________

Diagnostic Information
(To be completed by the appropriate health care professional)

Provider Name:______________________________________________________________________

Provider Title:______________________________________________________________

Address:__________________________________________________________________________

____________________________________________________________________________________

Provider Phone:______________________ Provider Fax:______________________________

• Impairment/Disability______________________________________________________________

• Date of Onset_______________________________________________________________

• Severity of the Impact: (Mild) (Moderate) (Severe)

• Please state any medication(s) the student is prescribed and if it alleviates functional limitations or if it contributes to functional limitations:______________________________________________________________

• Has the student been hospitalized within the last calendar year:_________________________

Provider should complete pages 2-4, sign and date page 4, and include any reports with additional information. If a comprehensive report is available providing the information requested, it can be submitted for documentation instead of this form.
**Disability Verification Form**

**Impairment in Major Life Activities:**

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>Unknown/Not Applicable</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Mobility</td>
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<tr>
<td>Concentration</td>
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<tr>
<td>Memory</td>
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<td>Social Interactions</td>
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<tr>
<td>Organization</td>
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<td>Attendance</td>
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<tr>
<td>Speaking</td>
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<td>Writing</td>
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<tr>
<td>Thinking (processing speed)</td>
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<td>Communicating</td>
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<td>Time Management</td>
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<td>Stress Management</td>
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<td>Managing internal distractions</td>
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<td>Eating</td>
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<td>Sleeping</td>
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<tr>
<td>Self-care</td>
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</tbody>
</table>
Disability Verification Form

Please describe any major activities impacted by the disability or symptoms that may need to be addressed in the college environment:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please state specific recommendations regarding accommodations for this student:
____________________________________________________________________________________
____________________________________________________________________________________
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Please describe student strengths and add any additional comments you feel are appropriate:
____________________________________________________________________________________
____________________________________________________________________________________
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Signature:______________________________________  Date:____________________________