TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
EL PASO

Verification of Disability Form

PROVIDER INFORMATION

Date

Provider Name (Last, First, Middle Initial)

License Number

Provider Street Address, City, ST, ZIP Code

Name of Organization

Primary Phone Number | Fax

Email Address

PATIENT INFORMATION

Date

Patient Name

Email Address

Primary Phone Number

Type of Request

X Access/copy

X Confidential communication

I (student) am requesting disability support services through the Office of Disability Support Services (DSS) at Texas Tech University Health Sciences Center El Paso. DSS requires current and comprehensive documentation of my disability/ medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to DSS by mail or fax. I authorize DSS to contact you if clarification is needed.

Student Signature

Date

The following area must be completed by the health care professional listed on this page.

1. Diagnosis(es) and date(s):

2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):

3. Current level of severity (choose one): Mild Moderate Severe

4. How long is this condition(s) likely to persist (e.g., lifetime, 1 academic year, etc.):

5. Please list procedures/assessments used to diagnose this student's condition:

6. What are the functional limitations or symptoms of this condition(s)?

7. What exacerbates this student's specific disability(ies)? (Please be specific.)

8. How does this condition impact the student's ability to learn or meet the demands of a university setting, clinical requirements, or other educational setting?

9. Identify any accommodations you believe may be necessary for the student to participate in the university's programs, activities, exams, and services:

Please attach any further documentation, if applicable.

Required attachments:

For ADD or ADHD: full testing evaluations

Deaf or hard of hearing: current audiogram

This information is current and accurate to the best of my knowledge, based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

Provider's Official Signature

Date

Thank you for your cooperation. You may fax or email your report using the information provided below. Please call if you require additional information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

Tammy Salazar, Ph.D.
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