Verification of Disability: Provider Form

This form is to be completed by a licensed and/or certified provider qualified to diagnose and/or treat the condition described. The provider should be a qualified clinician and must have comprehensive training with regard to the specific disability being addressed. Please respond to all applicable sections with as much detail as possible. Your responses will be used to determine eligibility for accommodations at Stanford University. Documentation should reflect the student's current functional impacts in the academic and/or housing environment.

Student Information:

Full Name	
Email Address	

Provider Information:

Full Name	
Professional Title and License/Certification	
Practice Name	
Phone Number	
Email Address	
Starting Date of Patient Relationship	
Date of Most Recent Evaluation	

Diagnosis and Disability Information:

Diagnosis (include DSM-5 or ICD-10 code):

Date of Original Diagnosis:

How was the diagnosis determined? Include relevant tests or assessments:

Functional Impact:

Describe how this condition substantially limits one or more major life activities (breathing, hearing, walking, reading, communicating, etc.) in the academic or housing environment. First, please describe the student's symptoms including severity, frequency and duration. Then please explain how the experience of these symptoms contribute to the limitations that the student experiences. Provide specific examples if possible.

Treatment and Prognosis:

Current treatment plan (if any):

Is this condition currently considered temporary or ongoing? If temporary, what is the expected duration of the condition?

Are symptoms expected to improve, remain stable, or worsen over time?

Accommodation Recommendations:

Please list any accommodations you believe would mitigate the functional limitations noted above. Please include a rationale for each accommodation request that explains why it is necessary to adequately address a specific limitation.

Attestation:

By signing below, I confirm that I am not a family member, friend, or anyone with a personal relationship to the student. I certify that I am qualified to diagnose and/or treat the above condition, and that the information provided is accurate to the best of my knowledge.

Provider Signature:	
License/Certification:	
Date:	

Upon completion, return this form to the Stanford University Office of Accessible Education by email at oae-contactus@stanford.edu or by sending it to your Disability Adviser.