Concordia University Texas
Disability Services
11400 Concordia University Dr.
Austin, TX 78726
FAX: 833.790.5307

Rheaann.spiegel@concordia.edu

Medical Disability Verification Form

Under the ADA Amendments Act of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations.

The student named below has applied for academic accommodations due to a medical or physical disability at Concordia University Texas. To help determine eligibility and appropriate services, we request current documentation of the student's condition and present limitations.

After completing this form, please return it to the student or, with the student's permission, you may return it to our office. The information you provide will be held confidential and will not become part of the student's educational records. In addition to the requested information, please attach any reports that provide additional related information. Please contact us at 512.313.4302 or FAX 833.790.5307 if you have any questions or concerns. Thank you for your assistance.

Consent For External Release of Information

I, ________________________________, authorize ____ to release to Disability Services at Concordia University Texas any and all information that is relevant to my disability, the functional limitations imposed by my disability and any recommendations of possible accommodations including, but not limited to, the information in the attached form.

Student Signature: ____________________________________ Date: _________________

Questionnaire to be completed by Qualified Professional

1. Student's Name (Last, First, Middle): ___________________________________

2. What is the student's primary diagnosis?
____

3. Date of Diagnosis: _____/______/________ Date of Initial Diagnosis: _____/______/________

   Approximate date of onset? _____/______/________

4. Date student was last seen: _____/______/___________

5. What is the severity of the disorder? _____ Mild _____ Moderate _____ Severe
   Please describe the severity checked above:
   ____

6. If the student experiences flare-ups or episodes, what is the relative frequency of such issues?
   ____ Daily _____ Weekly _______ Monthly _____ Sporadic and infrequent
7. List current medications, impact, and side effects:
   ____
   ____
   ____
   ____

8. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically (such as attendance; ability to complete specific physical tasks and so forth):
   ____
   ____
   ____
   ____

9. Please check any major life activities listed below that are affected by his/her medical condition and indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Personal Care (bathe, dress, shower, etc)				
Manual Tasks (write, draw / use mouse or stylus)				
Personal Organization / Planning Etc.				
Seeing				
Hearing				
Eating / digestion				

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Sleeping				
Waking Up				
Standing				
Walking, stairs etc.				
Lifting				
Bending				
Speaking				
Breathing				
Learning				
Reading				
Concentrating				
Thinking				
Communicating				
Written Composition (essays etc.)				
Attending Class / Work				
Note taking				
Other (specify)				

10. Based on the items checked above and any other functional limitations, describe how the disability diagnosis affects this student's life and education in college? Consider residence halls, classes, homework, mobility, academic skills etc.

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11. Do you have any specific recommendations regarding accommodations for this student? Please explain your rationale for these recommendations.

____

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____

____

____

12. What else you should we know about this student?

____

____

____

13. Please list any referrals you suggest for obtaining additional medical testing/evaluation for this student:

____

____

____

Certifying Professional:

______________________________	______________________________
Signature of Professional	Date
______________________________	______________________________
Professional's Name (Printed) and Title	Name of Practice
______________________________	______________________________
Professional Credentials	License or Certification No.
______________________________	______________________________
Address	Telephone No.
______________________________	______________________________
City, State, Zip	Fax

Contact Information:
Rhea Ann Spiegel, Manager
Academic Support Center

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