



**Concordia University Texas
Disability Services**

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

Ruth.cooper@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 512.313.5031 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				

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:
Ruth Cooper, Director
Disability Services**

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