HUMBOLDT STATE UNIVERSITY

Student Disability Resource Center

Please submit Completed Form To:
Student Disability Resource Center
Humboldt State University
1 Harpst Street
Arcata, CA 95521
Phone: 707-826-4678 Fax: 707-826-5397
Please do not email confidential information

Disability Verification

Documentation Determination

The student named below may be eligible for academic accommodations provided through the Student Disability Resource Center at Humboldt State University. In order to provide services, we must have a determination of a disability from his/her practitioner. Please be assured that the information provided by you will remain confidential in SDRC and will not be released to other persons unless instructed to do so by the student.

Please note: Student medical records supplied to this office constitute "education records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

Section 1: Student Information (To be completed by student)

Name: _____ HSU ID #: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ HSU email: _____

I authorize the release of the information requested on this Disability Documentation Form to the Student Disability Resource Center, Humboldt State University.

Signature: _____ Date: _____

REMAINDER OF FORM TO BE COMPLETED BY PRACTITIONER

Feel free to attach additional information, documentation, and/or reports

Section 2: Diagnosis(es)

Please describe the diagnosis(es). If appropriate, include the DSM diagnosis and information.

DIAGNOSIS 1:

_____

This diagnosis is considered: ☐ Permanent ☐ Progressive ☐ Temporary End Date: _____

DIAGNOSIS 2:

_____

This diagnosis is considered: ☐ Permanent ☐ Progressive ☐ Temporary End Date: _____

DIAGNOSIS 3:

_____

This diagnosis is considered: ☐ Permanent ☐ Progressive ☐ Temporary End Date: _____

Section 3: Method(s) of Determining Diagnosis: (Please check all that apply)

- ☐ Comprehensive Diagnostic Evaluation
- ☐ (Neuro) Psychological Assessment
- ☐ Consultation with Former Care Provider
- ☐ Clinical Interview
- ☐ Review of Medical Records
- ☐ Other

Section 4: Disability-Related Effects on Academic Performance. (Please check all that apply)

- ☐ Distractibility
- ☐ Agitation
- ☐ Decreased Concentration
- ☐ Confusion/Thought Disorder
- ☐ Inability to Focus
- ☐ Impaired Judgment
- ☐ Impaired Memory
- ☐ Intrusive Thoughts
- ☐ History of Impaired Performance on Timed Tasks
- ☐ Omissions
- ☐ Impulsivity
- ☐ Psychomotor Slowing
- ☐ Impaired Coordination
- ☐ Impaired Motor Function
- ☐ Inability to Sit for Extended Time
- ☐ Difficulty Sustaining Physical Energy Over Extended Periods of Time
- ☐ Chronic Pain

☐ Other (Please elaborate):

☐ Requires adaptive equipment to successfully perform routine tasks. Please specify:

☐ Difficulty completing timed tasks due to:

☐ Please provide additional information that will help us understand how this student's disability affects their academic performance:

☐ Please provide us with your recommendations for academic adjustments for this student:

Section 5: Medication-Related Functional Effects on Academic Performance

Functional limitations are substantial limitations in an individual's ability to perform a required major life activity as it relates to an educational setting (e.g. easily distracted, poor concentration, difficulty focusing for extended periods of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panics in unfamiliar surroundings and situations, etc.)

Name of Drug with Dosage	Purpose of Medication	Medications' Effects on Academic Performance (Please check all that apply)
1.	1.	☐ Confusion/Thought Disorder ☐ Sedation/Fatigue
2.	2.	☐ Decreased Concentration ☐ Agitation
3.	3.	☐ Impaired Coordination ☐ Distractibility
4.	4.	☐ Psychomotor Retardation
5.	5.	Other:

Additional Comments:

Section 6: Licensed Practitioner:

Name:

Address: City: State:

Zip Code: Phone Number: Fax Number:

License Number: Type of License:

Signature of Licensed Provider: Date: