

To be completed by a physician, psychologist, audiologist, ophthalmologist, or other licensed professional appropriately qualified to diagnose the specific disability of the individual.



Office of Disability Services
111 Reid Centennial Hall
500 8th Avenue
Lewiston, ID 83501
Office: 208-792-2211
Fax: 208-792-2453
www.lcsc.edu/osl/ada.htm

REQUEST FOR DISABILITY VERIFICATION OF PHYSICAL AND/OR SENSORY DISABILITIES (Audio / Visual / Auto Processing)

To ensure the provision of reasonable and appropriate services for students with physical or sensory disabilities, the Office of Disability Services requires students to provide current and comprehensive documentation of their disability and its impact on their education. Please complete and return this form to our office. We thank you in advance for your assistance.

Student's name: _____

1. Name/Type of Disability (diagnosis): _____

2. Describe any treatment plan(s), including a description of student's responsibility:

3. Indicate which major life activity(ies) is/are substantially limited by this disability/chronic health condition (circle all that apply): caring for oneself, performing manual tasks, seeing, hearing, speaking, breathing, learning, working, other: _____

4. Describe any additional functional limitations imposed by the disability/chronic health condition, particularly in an academic setting (e.g. writing, taking notes, carrying heavy awkward items distances over 200 feet, using stairs, walking distances in inclement weather, etc.).

5. Any suggested accommodations: _____

6. Summary and recommendations: _____

7. Signature of Physician Specialist

Signature: _____	Date: _____
Print Name and Title: _____	
Area of Specialty: _____	
State License: _____	License Number: _____
Address: _____	
Phone: _____	Fax: _____