UNIVERSITY OF MARYLAND
GLOBAL CAMPUS

DISABILITY VERIFICATION FORM
FOR STUDENTS WITH A
COMMUNICATION/LANGUAGE DISORDER

Accessibility Services

1616 McCormick Drive Suite 2434, Largo, MD 20774

Main line: 240-684-2287 Fax: 240-684-2590

To be completed by licensed Audiologist/Speech Pathologist

The following student _____has asked to register with Accessibility Services (AS) at University of Maryland Global Campus (UMGC). AS requires documentation of the student's disability in order to establish eligibility and provide appropriate services.

Under the Americans with Disabilities Act (ADA) 1990 and Section 504 of the Rehabilitation Act of 1973, students are protected from discrimination and may be entitled to reasonable accommodations. In compliance with the requirements set forth, this form is to verify that a disability exists and accompanying the disability are functional limitations. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and/ or services.

The information you provide will not become a part of the student's academic records but will be kept confidential, and placed into the student's file at AS. Indicated by the signature below, the student has given permission to release information to UMGC.

Signature of student _____ Date _____

After completing this form, please mail or fax the form to the address above. If you have any questions regarding the nature of the information requested on this form, please feel free to contact Accessibility Services at (240)684-2287 or accessibilityservices@umgc.edu . Thank you for your assistance.

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1. ASM-IV Diagnosis:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Date of initial Diagnosis: _____

Last contact with student: _____

1. What instruments and procedures were used to diagnose the disorder?

2. Describe symptoms that meet the criteria for the diagnosis and report all test results. Please attach diagnostic report if possible.

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3. Describe the functional limitations of this disorder for this student in an educational setting.

4. What recommendations do you have regarding academic accommodations and your rationale for these recommendations?

5. Briefly describe current treatment plan and assessment of the duration of this disorder if the condition is remediable.

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CERTIFYING PROFESSIONAL:

Printed Name and Title: _____

Signature/Professional Stamp: _____

Date: _____

License Number: _____

Address: _____

_____

Telephone: _____ Fax: _____

Number of years working with adult college students: _____