UT MARTIN
Office of Disability Services

VERIFICATION FORM FOR STUDENTS WITH A TEMPORARY DISABILITY

This form is intended to assist in meeting our documentation requirements for these disabilities. However, if not thoroughly completed, it may not be sufficient as the sole form of documentation provided. Please refer to the "Guidelines for Documenting a Temporary Disability/Injury" for comprehensive documentation requirements and additional information. This documentation should provide information regarding the date of diagnosis, approximate durations of the condition, and the functional limitations regarding how it interferes with educational achievement. To standardize our gathering of information, it is recommended that you complete the following questions, even if the material has already been included in your full evaluation. All information will be kept confidential. Please feel free to contact ODS at 731.881.7195 with questions.

THE INFORMATION BELOW IS TO BE COMPLETED AND SIGNED BY THE STUDENT.

I request and authorize The University of Tennessee at Martin's Office of Disability Services and/or my off-campus provider (name)_____to release, fax, mail or discuss with each other information related to my registering with the Office of Disability Services (ODS).

_____

Student Name EID

_____

Student Signature Date

_____

Email Address Phone Number

If the information above is left blank or is incomplete, it may delay or prevent ODS from contacting the student to verify receipt of the documentation and provide next steps for completing the registration process.

THE INFORMATION BELOW IS TO BE COMPLETED AND SIGNED BY THE PROVIDER.

1. Current diagnosis, injury, and/or condition:_____

_____

_____

a. Date diagnosed: _____/_____/_____

b. Approximate duration of diagnosis, injury, and/or condition:

_____ 2 weeks or less _____ 2-4 weeks _____ 4-8 weeks _____ 8-12 weeks _____

Unknown (please explain):_____

c. Current treatment/medication:_____

_____

2. Functional Limitations

a. Does this condition significantly **limit one or more of the following major life activities**?

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the current **functional limitations or behavioral manifestations** for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don't Know
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending Class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

3. Accommodations

(Optional) Recommended educational accommodations, including course load reduction:_____

_____

_____

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information on the next page. This form should be signed and returned via fax or mail to the ODS office at the address shown at the end of this document.

All documentation submitted to ODS is considered confidential.

PROVIDER INFORMATION

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:_____ Date:_____

Print Name and Title:_____

_____

State of License:_____ License Number:_____

Address:_____

Street or P.O. Box City State Zip

Phone:_____ Fax: _____

ATTACH PROVIDER BUSINESS CARD HERE

PLEASE RETURN THIS FORM TO:

UT MARTIN
OFFICE OF DISABILITY SERVICES

206-209 Clement Hall
DisabilityServices@utm.edu
731.881.7195
Fax: 731.881.7702