STUDENT ACCESSIBILITY SERVICES
CFCC

DISABILITY VERIFICATION FORM

(ALL BLANKS IN THIS SECTION MUST BE COMPLETED BY THE STUDENT)

I, (PRINT STUDENT NAME) ______________________________ , hereby authorize the release of the following information for the purpose of determining my eligibility for academic accommodation(s), as based on the federal guidelines for the definition of a disability.

___________ ________________________________ ______________________________

Date Signature of Student Date of Birth

___________________________ ___________________________ ______________________________

Student Phone Number CFCC Student ID Last 4 digits of Student SSN

(ALL BLANKS IN THIS SECTION MUST BE COMPLETED BY A HEALTHCARE PROVIDER)

Complete both sides, one verification form for each diagnosis. Please note the following information:

- **Intellectual disability and learning disability** diagnoses must be accompanied by a current, appropriate diagnostic evaluation that includes test scores.
- **Visual or hearing loss** diagnosis must be accompanied by an acuity and/or audiology report that addresses the current impact of the diagnosis, as well as information about the specific assistive technology used by the student.

Diagnosis & either DSM or ICD code (please provide diagnosis and code): ____________________________

Level of Severity: ☐ Mild ☐ Moderate ☐ Severe

Diagnostic Criteria: List the diagnostic assessments used in making this determination:

____

Date of Diagnosis: ________________________ **Date of Last Visit:** __________________________

Frequency of office visits: _________________________________

Does this condition interfere with one or more of the following major life activities? (Check all that apply)

☐ Walking	☐ Reading	☐ Learning	☐ Eating	☐ Speaking	☐ Communicating
☐ Lifting	☐ Hearing	☐ Standing	☐ Manual tasks	☐ Sleeping	☐ Concentrating
☐ Working	☐ Bending	☐ Seeing	☐ Thinking	☐ Breathing	☐ Caring for one’s self

Describe the student’s condition, symptoms, and the impact on life activities, including academics:

____

____

Treatments, medications (including side effects), assistive devices/services currently prescribed or in use:

____

____

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RECOMMENDED ACCOMMODATION(S):

____

____

____

Note: Recommendations are welcomed and considered; however, SAS makes the ultimate determination on eligibility and reasonable accommodations necessary to provide equal access for participation in academic courses, programs, and activities. Recommendations should be directly linked to the impact or functional limitations associated with the disability.

Provider's Name: _______________________________ **Title:** __________________ **License #:** __________

Practice/Clinic Name: ____________________________

Address: ____ **Phone:** ____________________________

Fax: ______________________________

I, the undersigned, certify that the information provided for the student is true and correct to the best of my knowledge. I confirm that I am licensed or otherwise qualified to diagnose the conditions listed and have adequately evaluated the student.

Signature ____ **Date** ____________________

Please return/fax to:

Cape Fear Community College – Student Accessibility Services

411 N. Front Street
Wilmington, NC 28401

Phone: (910) 362-7017
Fax: (910) 362-7113
Email: sas@cfcc.edu

Confidential

The information is provided by the Student Accessibility Services office for the purpose of educational planning. We appreciate the respect for the student's confidentiality and your understanding that state and federal laws prohibit the release of this information to any other person or agency or for use in any manner for any other purpose. Students with disabilities are eligible for appropriate services stipulated under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Student Accessibility Services has received all necessary documentation that substantiates the student's need for academic accommodations.