Office of Accessibility and Accommodations
Eastern Illinois University
600 Lincoln Ave
Charleston, IL 61920
217-581-6583

PROVIDER VERIFICATION OF DISABILITY

Student: This form should be completed by a certified mental/medical health provider. This form will not be accepted if you have completed it yourself.

Provider: The following form can be completed to support the student's disability conditions by a relevant healthcare provider (psychologist, psychiatrist, therapist, licensed clinical social worker, medical doctor, optometrists, etc.) who is not a family member of the student and/or who does not have an inherent conflict of interest. Please include as much detail as possible regarding the student's disability, as this helps the Office of Accessibility & Accommodations to make informed decisions on accommodation requests. This information will be used in conjunction with the student's self-report to determine reasonable accommodation on an individual basis.

Student's Full Name: _____

E#: _____ Date of Birth: ____/____/____

Diagnosed disability or disabilities for which accommodations are being requested: _____

_____

DSM Code(s) (if applicable): _____

Date of Diagnosis: ____/____/____

Does the disability limit one or more major life functions? ☐ Yes ☐ No

Is the student in treatment with you for the disability? ☐ Yes ☐ No

What is the projected duration of the disability? ☐ Permanent ☐ Temporary

First contact w/ student: ____/____/____ Most recent contact: ____/____/____

What symptoms does the student experience regarding this disability? What is the severity and frequency? What, if anything, triggers symptoms or episodes? Please be specific:

_____

_____

_____

_____

_____

Is the student prescribed medication? If so, what side effects, if any, does the student experience that may have an educational impact? Please include severity and frequency:

_____

_____

Describe the impact and functional limitations of the condition relative to the post-secondary academic environment.

_____

_____

_____

_____

_____

Prognosis: Describe the anticipated progression or stability of the disability including any recommendations for future reevaluation:

_____

_____

_____

Functional Limitations: Please rate the current impact of the disability on the student's ability to function independently, appropriately, and effectively on a sustained basis in regard to the following major life activities.

- **Mild**: slight limitation, very manageable
- **Moderate**: noticeable interference, may struggle to perform without some adjustments
- **Severe**: substantial impact, requires greater accommodation, may be unable to perform function

Spelling	☐ Mild	☐ Moderate	☐ Severe	☐ None
Reading	☐ Mild	☐ Moderate	☐ Severe	☐ None
Written Expression	☐ Mild	☐ Moderate	☐ Severe	☐ None
Calculating	☐ Mild	☐ Moderate	☐ Severe	☐ None
Concentrating	☐ Mild	☐ Moderate	☐ Severe	☐ None
Following Direction	☐ Mild	☐ Moderate	☐ Severe	☐ None
Learning	☐ Mild	☐ Moderate	☐ Severe	☐ None
Memorizing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Thinking/Processing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Test Taking	☐ Mild	☐ Moderate	☐ Severe	☐ None
Communicating/Speaking	☐ Mild	☐ Moderate	☐ Severe	☐ None
Hearing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Seeing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Gross Motor	☐ Mild	☐ Moderate	☐ Severe	☐ None
Walking/Standing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Sitting	☐ Mild	☐ Moderate	☐ Severe	☐ None

Handwriting	☐ Mild	☐ Moderate	☐ Severe	☐ None
Interacting with others	☐ Mild	☐ Moderate	☐ Severe	☐ None
Fine Motor/Manual Tasks	☐ Mild	☐ Moderate	☐ Severe	☐ None
Attending Class/Participating	☐ Mild	☐ Moderate	☐ Severe	☐ None
Breathing	☐ Mild	☐ Moderate	☐ Severe	☐ None
Sleeping	☐ Mild	☐ Moderate	☐ Severe	☐ None
Other Major Body Functions	☐ Mild	☐ Moderate	☐ Severe	☐ None
Caring for Self	☐ Mild	☐ Moderate	☐ Severe	☐ None

Other/Comments/Notes:

_____

_____

_____

_____

What, if any, previous accommodations has the student utilized that you are aware of?

_____

_____

_____

Does the student have any current/ongoing medical restrictions as a result of their disability? If so, please describe:

_____

_____

_____

Certifying Professional Information:

By my signature below, I certify that the information provided above is true and accurate. I confirm I have expertise, history, and knowledge of the student's impairment, which meets the standards of a disability as defined by the ADA, as amended.

Physician/Clinician Name: _____

Medical Specialty: _____

License/Certification #: _____

Address _____

Phone #: _____ Email: _____

Signature: _____ Date: ____/____/____

This information will be kept confidential and will not be included in the student's educational record. This document may not be released without written permission from the student, or in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA).

All information provided in this form will be considered but it is not the definitive information that informs our final decisions. Final determination will be decided by Eastern Illinois University in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act Amendments of 2008.

Office of Accessibility & Accommodations
(217)-581-6583 (Phone)
(217)-581-7208 (Fax)
accommodations@eiu.edu

NOTE: This form has been approved for use as of June 1, 2025. The institution reserves the right to update this form, as appropriate, at any time.