Department for Disability Support Services
East Carolina University
Slay 138 • Greenville, NC 27858-4353
252-737-1016 voice/TDD • **252-737-1025** fax

ADA & ADAA Disability Verification Form

East Carolina University is committed to compliance with the Americans with Disabilities Act (1990) and the Americans with Disabilities Amendments Act (2008). The purpose of this form is to assist East Carolina University in determining whether, or to what extent, a reasonable accommodation will allow a student access to equal opportunity in educational pursuits.

To be completed by the student:

Name:_____

By my signature below I hereby authorize my health care provider _____ to furnish the following information to the Office of Disability Support Services at East Carolina University. I further agree that the Director of Student Services may contact my health care provider named above to obtain additional information related to my limitations and recommended accommodations. I understand that relevant information obtained may be shared with my supervisor(s) and other University offices that may be involved in assisting with the establishment of reasonable accommodations.

_____ _____
Signature Date

To be completed by the health care provider:

Please list diagnoses that are related to the student's ability to perform essential academic tasks and/or live independently in a residence hall.

Primary Diagnosis _____ Date of Diagnosis _____

Is the condition listed above (please circle) permanent temporary episodic
- If temporary, estimated length of recovery period _____
- If episodic, estimated length of time between flare-ups _____

Is the condition listed above (please circle) mild moderate severe

Secondary Diagnosis _____ Date of Diagnosis _____

Is the condition listed above (please circle) permanent temporary episodic
- If temporary, estimated length of recovery period _____
- If episodic, estimated length of time between flare-ups _____

Is the condition listed above (please circle) mild moderate severe

Please list any other comorbid diagnoses:

According to the Americans with Disabilities Amendments Act, *major life activities* may include but are not limited to the following, please check all that are impacted by the physical or mental impairment of the student:

- ❑ caring for oneself
- ❑ performing manual tasks
- ❑ seeing
- ❑ hearing
- ❑ eating
- ❑ sleeping
- ❑ walking
- ❑ standing
- ❑ lifting
- ❑ operation of a major bodily function
- ❑ bending
- ❑ speaking
- ❑ breathing
- ❑ learning
- ❑ reading
- ❑ concentrating
- ❑ thinking
- ❑ communicating
- ❑ working

Does the student's physical or mental impairment significantly impact any of the following school-related activities?

- ❑ understanding lectures
- ❑ concentrating during class
- ❑ taking notes in class
- ❑ participating in class
- ❑ ability to live independently in a residence hall
- ❑ communicating with professors
- ❑ communicating with peers
- ❑ completing assignments
- ❑ taking exams
- ❑ reading materials for class

Please list any other impairments not presented above:

_____

_____

Given the limitations described above and your knowledge of the academic and residential activities of the student, what accommodations do you recommend that will enable the individual to perform the essential functions of these activities?

_____

_____

_____

_____

_____

_____

Provider Information

Name: _____ Area of specialty: _____

Practice Address:

_____

_____

Phone: _____

Fax: _____

_____ _____

Signature Date