



Office of Accessibility & 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. Please do not check more than one box per limitation listed.

- **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
- **None:** no limitation or no limitation observed

Spelling	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Reading	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Written Expression	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Calculating	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Concentrating	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Following Direction	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Learning	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Memorizing	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Thinking/Processing	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Test Taking	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Communicating/Speaking	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Hearing	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Seeing	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Gross Motor	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Walking/Standing	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None
Sitting	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe	<input type="checkbox"/> None

- | | | | | |
|-------------------------------|-------------------------------|-----------------------------------|---------------------------------|-------------------------------|
| Handwriting | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Interacting with others | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Fine Motor/Manual Tasks | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Attending Class/Participating | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Breathing | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Sleeping | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Other Major Body Functions | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> None |
| Caring for Self | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe | <input type="checkbox"/> 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.