

DISABILITY VERIFICATION
Medical Condition/ Chronic Health Disabilities
(to be completed by diagnosing or current physician)

Please read the following prior to completing this form:

Disability Support Services at Western Nevada College provides support services to students with diagnosed disabilities, including serious medical condition and chronic health disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires current and comprehensive documentation of the disorder from their diagnosing or current physician. This should include information that describes the onset of the disability, its manifestation, and recommendations for accommodation in the higher education academic setting.

Please note that eligibility for services is determined based on a review of this information, in accordance with criteria established in Section 504 of the Rehabilitation Act of 1973, and in cases pertaining to the Americans with Disabilities Act. It is therefore imperative that comprehensive information be provided so that the Disability Specialists can make an appropriate determination about the student's eligibility to receive disability-related accommodations under the law. Confidentiality of the information provided is ensured, and will in no way become part of the student's academic record. Please feel free to contact the Disability Support Services office with any questions or concerns you might have regarding the information you are being asked to provide. Thank you for your assistance.

Please provide the following information about:

1. Diagnosis:

Date of Diagnosis:

Last contact with student:

2. Describe the symptoms associated with this medical condition & the student's prognosis:

3. Describe how this medical condition will likely impact the student's progress in the college:

4. List current medication, dosage, frequency and possible adverse side effects:

5. List any other treatment the student is receiving to manage his/her condition:

6. List any recommendations for accommodations in an academic setting you have for this student (i.e. extra time for exams, different type of chair, lighting, room/furniture modifications, more time on exams, note taker, etc:)

7. Please describe any specific concerns you may have, or other ways that we may be of further assistance to this student:

Physician Signature: _____ Date: _____

Printed Name and Title: _____

Address:

Telephone: () _____

Please mail or fax this form to:

Susan Trist, M.A., CRC, CDMS
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Disability Support Services
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2202 West College Parkway
Carson City, NV 89703

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