COMMONWEALTH UNIVERSITY OF PA

DISABILITY VERIFICATION FORM

Part I: Student Information

First Name_____ **Middle**_____ **Last** _____

BU ID_____ **Date of Birth** _____

Status (check one) ☐ **Current Student** ☐ **Transfer Student** ☐ **Prospective Student**

If prospective, what month and year are you beginning _____

Local phone (_____) -_____-_____ **Cell phone (_____) -_____-_____**

If current BU student, email address_____**@huskies.bloomu.edu**

Student's signature: _____

Part II: Diagnostic Information

(To be completed by the health care provider)

1. **Date of Diagnosis:** _____
2. **Primary Diagnosis:** _____
   - **Secondary Diagnosis:**

     _____
3. **What is the severity of the disorder?** ☐ **Mild** ☐ **Moderate** ☐ **Severe**
4. **State specific recommendations regarding academic accommodations for this student:**

(Continue to next page)

Part III: Health Care Provider Information
(To be completed by the health care provider. Please completely fill in all fields.)

Provider Signature _____ **Date**_____

Provider Name (print) _____

Title _____

License or Certification # _____

Address _____

_____

Phone Number (____) -_____- _____

Fax Number (____) - ___- _____

For Office Personnel Only:

Name of preparer: _____