THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Disability Support Services
Rome Hall
801 22nd Street, NW Suite 102
Washington, DC 20052
Phone: 202-994-8250
dss@gwu.edu

Disability Verification Form

Disability Support Services (DSS) provides accommodations for students with diagnosed disabilities. The purpose of this form is to assist treatment providers in documenting a student's relevant disability information for determining accommodation eligibility.

To the Treatment Provider: A GW student has requested disability related accessibility accommodations. The information you provide below will be used to determine the appropriateness of the requested accommodations. With the student's permission, we may contact you directly for additional information to assist us in making a determination. **All information provided to us is confidential.**

Please complete this form as thoroughly as possible. Inadequate information may delay the eligibility review process. The following information is generally needed in order to determine the most appropriate reasonable accommodations:

1. That the student has an impairment that substantially limits a major life activity
2. How the diagnosis impacts the student in a university environment
3. How the requested/recommended accommodations mitigate the impact of the diagnosis

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Student Name **Student GWID:**

Diagnosis/Diagnoses (with DSM-V / ICD-10):

Date of Onset:

Date Last Seen:

Frequency of visit, if applicable?

Provide a summary of your assessment of the diagnosis(es) above:

Current status of diagnosis(es): Active or in remission? How long will this condition likely exist?

Please describe current functional limitations, impairments, and symptoms that substantially limit one or more major life activities:

Describe the conditions or circumstances which significantly exacerbate the condition and their potential impacts:

Current treatment plan:

Current medication(s) and potential side effects:

Please advise on academic, housing, dining or other accommodations requested. What accommodations should be considered and why?

REQUIRED INFORMATION:

Name and Title of Physician or Licensed Clinical Provider:

Address:

Telephone:

E-mail:

Physician/Provider Signature (stamped signatures are not solely accepted): _____

Date:

Physician/Provider Identification Number: