Kansas City University
KANSAS CITY, MISSOURI • JOPLIN, MISSOURI

Student Verification of Disability Form

Student Name: _____ Birth Date: _____

I, _____, authorize the release of necessary confidential medical information regarding my disability. I am requesting disability accommodations through the Disability Services Office at Kansas City University. The school requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to the disability office by email or fax. I authorize the Disability Services Office to contact you for clarification if needed.

Student Signature: _____ Date: _____

Healthcare provider name (print): _____

Credentials: _____ Phone: _____ Fax:_____

Organization and address: _____

_____

The following area must be completed by the healthcare professional listed on this page. Page 4 may be utilized if additional space is required.

1. Diagnosis(es) and date(s):

2. Current status of condition(s) (e.g., active, progressing, controlled, in remission):

3. Current level of severity: ☐ Mild ☐ Moderate ☐ Severe

4. How long is this condition(s) likely to persist (be as specific as possible—e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month, temporary):

Disability Services Office
Accommodations@kansascity.edu
T 816.654.7314 • Fax 816.654.7311
1750 Independence Ave • Kansas City, MO 64106

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5. Evaluations used for the diagnosis(es) (check all that apply):

☐ Clinical Interview ☐ Psychometric Testing ☐ Diagnostic Study ☐ Physical Exam

☐ Other (please explain):

6. What are the functional limitations or symptoms of the condition(s)?

7. Do these limitations substantially impair a major life activity as compared to most people in the general population? ☐ Yes ☐ No

If yes, which major life activity(s) (includes major bodily functions) is/are affected?

☐ Bending	☐ Hearing	☐ Reaching	☐ Speaking	☐ Other: (describe)
☐ Breathing	☐ Interacting with Others	☐ Reading	☐ Standing	
☐ Caring for Self	☐ Learning	☐ Seeing	☐ Thinking	
☐ Concentrating	☐ Lifting	☐ Sitting	☐ Walking	
☐ Eating	☐ Performing Manual Tasks	☐ Sleeping		

Major bodily functions:

☐ Bladder	☐ Digestive	☐ Lymphatic	☐ Reproductive
☐ Bowel	☐ Endocrine	☐ Musculoskeletal	☐ Respiratory
☐ Brain	☐ Genitourinary	☐ Neurological	☐ Special Sense Organs & Skin
☐ Cardiovascular	☐ Hemic	☐ Normal Cell Growth	☐ Other: (describe)
☐ Circulatory	☐ Immune	☐ Operation of an Organ	

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8. How does the substantial limitation(s) (and/or current treatment) impact the student's ability to learn or meet the demands of the university setting and/or clinical requirements?

9. Identify any accommodations you believe may be necessary for the student to participate in the university's programs, activities, and services:

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Providers name (Please print): _____

Professional license or specialty: _____

Physician/Clinic Stamp or Seal
Signature required if no stamp available

_____
Signature

_____
Date

Thank you for your cooperation. You may email or fax your report to the Disability Services Office.
Please attach any additional reports or relevant information.
All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

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