COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

DOCUMENTATION VERIFICATION FORM

Accessibility and Counseling Center (ACC) at the College of Central Florida provides accommodations and services for students with disabilities with the intent to help facilitate equal access to educational opportunities. This form must be completed by a licensed professional qualified to diagnose and treat the condition (e.g., medical professional, psychiatrist, licensed psychologist, licensed social worker).

Student Authorization Section

I (print student name), _____ , authorize (provider name), _____ , to complete and provide a copy of this form to the College of Central Florida Accessibility and Counseling Center (ACC).

Student Signature	Date of Birth	Signature Date
_____	_____	_____

Healthcare Provider Section

The following information is to be completed and signed by the provider.

Date of first contact with your office: _____

How often is the patient seen? _____

Date of last contact: _____

Please fill in the information below about diagnosis(es):

Date of Diagnosis	Diagnosis	DSM-V or ICD Codes	Anticipated Duration of Diagnosis

Check off all sources used to verify diagnosis:

☐	Psychological testing	☐	Family history
☐	Neuropsychological testing	☐	Medical evaluation
☐	Psychoeducational testing	☐	Diagnostic (X-ray, lab work, MRI, etc.)
☐	Structured or unstructured interview	☐	Medical history supporting current presentation of symptoms
☐	Behavioral observations	☐	Other: _____ _____ _____ _____
☐	Academic history Individualized Education Plan (IEP), 504 Plan, teacher reports, etc.		

Current Treatment:

☐ Medication Management: List any side effects that may impact academic performance:

_____

☐ Outpatient Counseling/Therapy - Number of visits per month: _____

☐ Physical/Occupational Therapy - Number of visits per month: _____

☐ Speech Therapy – Number of visits per month: _____

☐ Other (please describe):

_____

Explain how the student's disability impacts performance in a classroom setting (e.g., speaking, note taking, concentration, processing speed):

Explain how the student's disability impacts performance on timed tests (e.g., levels of anxiety/stress, memory, concentration, processing speed):

If applicable, explain how the student's disability might impact their ability to speak in front of a class (e.g., class participation, public speaking):

Please provide any additional information you feel will be useful in determining appropriate accommodations and services:

<u>Complete this section ONLY</u> when chronic health conditions impact attendance and/or course deadlines:

How often do medical episodes occur and how long do the symptoms last?

Describe the impact of the symptoms:

Date of last known episode:

Does the episode/condition require hospitalizations? ☐ Yes ☐ No If yes, typical duration:

Does the condition require regular treatments such as infusions, radiation? ☐ Yes ☐ No If yes, describe the side effects.

Any upcoming surgeries related to the condition: If yes, date and expected recovery time?

Healthcare Provider Information

I certify by my signature that all information in this document is accurate and the patient is under my care. Signature: _____ Date: _____

Print Name: _____ Print Title: _____

State of License: _____ License Number: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Telephone No.: _____

It is preferred that this completed document is returned directly to the requesting student. Alternatively, it can be submitted to the CF Accessibility and Counseling Center (ACC) via email at Disability@CF.edu or mailed to:

Accessibility and Counseling Center
College of Central Florida
3001 S.W. College Road
Ocala, FL 34474-4415