SOUTHERN UNIVERSITY SYSTEM
BATON ROUGE • NEW ORLEANS • SHREVEPORT

DISABILITY VERIFICATION FORM

CONFIDENTIALITY STATEMENT:
A request for accommodation, including medical and other relevant information, is privileged and may only be released as appropriate to individuals with a business need to know.

SECTION 1: STUDENT'S INFORMATION

Student's Name:_____ Campus Name:_____

Banner (U) Number:_____ Date of Birth:_____
Address:_____
Email Address:_____ Student's Phone #:_____
Gender: ☐ Male ☐ Female ☐ Other: _____ ☐ Prefer Not to Answer

Semester Accommodations Being Requested: ☐ Fall ☐ Spring ☐ Summer, 20____

Classification: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate Student
☐ Dual Enrollment ☐ Non-Degree Student
For SULC Students Only: ☐ 1L ☐ 2L ☐ 3L ☐ 4L

Authorization for Release of Medical Information

I authorize my Healthcare Provider to release medical information that is specifically related to and necessary for my university to determine whether I have a disability for which an accommodation(s) may be needed. I authorize my Healthcare Provider to speak directly to my university's Disability Services Coordinator or designee regarding my medical condition and my request for accommodations under the Southern University System's Disability Services Policy. I understand that I may refuse to sign this Authorization. However, I understand that my failure to permit these disclosures may impact my university's ability to fully address my request for accommodation.

Student's Signature: _____ Date: _____

The following shall be completed by a licensed medical professional.

Diagnosis: _____

Date of Diagnosis: _____ Date of Last Contact with Student: _____

What is the nature of the student's disability?

Duration of disability: ☐ Permanent ☐ Temporary ☐ Chronic/Recurring

Does the student require ongoing treatment? ☐ Yes ☐ No

Describe the student's functional limitations in an education setting.

List all medications or current treatment being used.

Please state recommendations you have regarding academic accommodations (e.g., extended exam time, assistive technology, private testing environment, etc.).

Licensed Medical Professional's Signature: _____

Printed Name and Title: _____

License or Certification Number: _____

Telephone Number: _____

Address: _____

Date: _____

Please return the completed form to the respective Disability Services Coordinator.

www.sus.edu/compliance