Learning Support Services (LSS) – LA 115
4800 East Huron River Drive
Ann Arbor, Michigan 48105

Tel: (734) 973-3342
Fax: (734) 477-8517
learningsupport@wccnet.edu

Disability Verification

The student named below may be eligible for services offered through Learning Support Services. In order to provide these services, verification of the student's disability is required. Please note: The determination of actual services and accommodation will be made by Learning Support Services (LSS).

Student's Name: _____
Last First MI

WCC
ID Number: @_____ Date of Birth: _____

I authorize the release of the information requested below to Learning Support Services (LSS) at Washtenaw Community College.

_____ _____
Student's Signature Date

To be completed by a licensed PROFESSIONAL:

1. Diagnosis:_____
2. DSM-5 or ICD-10 diagnostic code(s):_____
   _____
   _____
   _____
3. Level of severity: Mild _____ Moderate _____ Severe _____ Partial Remission _____
4. Date of diagnosis: _____
5. Date of last office visit:_____
6. Assessment/evaluation procedures. Attach scores of all tests administered. (If available, please include a psychoeducational report):
   _____
   _____
   _____
   _____
   _____
   _____
   _____

Please continue on second page

Student's Name: _____

7. Relevant background information:
   _____
   _____
   _____
   _____

8. How does the student's disability affect his/her ability to function in an academic environment (e.g. mobility, classroom activities, test taking, memory or perception, etc.)?
   _____
   _____
   _____
   _____

9. Current prescribed medications related to disability (mitigating the effects of the disability and/or causing side effects related to student's educational functioning):

Medication	Dose/Frequency	Effects/Side Effects
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

Name of Professional (Please print): _____

Signature of Professional: _____

License #: _____
Date: _____
Address: _____
_____

Phone and FAX: _____

Return this form to our office as soon as possible so that this student may begin participation in our program. Please include any verifying documents from your files.