Disability Support Services

**Temporary Disability Verification Form**

The Disability Support Services (DSS) office provides academic accommodations and services to students with **Temporary Disabilities**. Students seeking accommodations must provide appropriate documentation of their disability so that DSS can determine the student’s eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. A **temporary disability** is one that will resolve within three to six months. For impairments requiring accommodations for six months or longer, please refer to our traditional accommodation process. To verify the disability and its severity, DSS requires the form below to be completed by the current treating licensed healthcare provider.

**Student name:** Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ LOYOLA ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For the current treating healthcare provider to complete:**

1. Diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Date of your last clinical contact with student:\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

3. The extent of the condition is: Mild Moderate Severe

4. Expected duration of temporary disability is: 1-3 months 3-6 months 6-12 months

5. Suggested Accommodations

Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis.

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6. Please attach any relevant evaluation results or reports.

Thank you for your help in providing this information so that we may begin services as soon as possible. This form should be signed and returned to DSS at the address shown at the end of this document.

**Provider Information:**

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

**If filling out online, in lieu of signature, please click here to certify that the above statement is true.**

**Y 🞏 N🞏**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State of License: \_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street or P.O. Box City State Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please return this signed form to:**

Disability Support Services

Loyola University Maryland

4501 North Charles Street

Baltimore, MD 21210

dss@loyola.edu [www.loyola.edu/dss](http://www.loyola.edu/dss) or fax (410) 617-2080