DIVISION OF DIVERSITY AND COMMUNITY ENGAGEMENT

THE UNIVERSITY OF TEXAS AT AUSTIN

Services for Students with Disabilities •100 W. Dean Keeton St. A4100 • Austin, TX 78712-0175
www.ddce.utexas.edu/disability (512) 471-6259 • FAX (512) 475-7730 • VP (512)-410-6644

Verification Form for Housing and Dining Accommodations

Student's Name:_____**EID**_____

I authorize the University of Texas of Austin-Services for Students with Disabilities to receive information from my provider (name)_____. I also authorize my provider to discuss my condition(s) with the appropriate and qualified University of Texas at Austin personnel on an as needed basis.

Student Signature:_____ Date:_____

In order to determine reasonable accommodations for housing and/or the associated dining plan, the University of Texas at Austin requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider who is familiar with the student and their diagnose disability and the impact it has on their functioning. *The provider completing this form cannot be a relative of the student.* If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).

1) Date of Initial Contact with Student: _____
2) Date of Last Office Visit with Student: _____
3) ***Diagnosis:*** Please list all relevant diagnoses. If applicable, please list all DSM 5 or ICD Diagnoses (text and code):

_____

_____

4) Approximate onset of diagnosis: _____/_____/_____

Severity of symptoms
- o mild
- o moderate
- o severe

Prognosis of disorder:
- o good
- o fair
- o poor

5) Describe the symptoms related to the student's condition that cause **significant** impairment in a major life activity.

_____

_____

_____

_____

6) Please list the specific accommodation(s) you recommend to provide the student with equal access to campus housing and/dining:

_____

_____

7) Please explain why the housing or dining accommodation(s) listed above are necessary to provide this student with equal access to their living/dining experience on our campus based on the impact of their disability. There must be an identifiable relationship between the student's disability and the accommodation being requested.

_____

_____

_____

_____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to the SSD office at the address shown at the end of this document.

All documentation submitted to SSD is considered confidential.

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.

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____ License Number: _____

Address: _____

Phone: _____ Fax: _____

Please return this form to:
The University of Texas at Austin
Division of Diversity and Community Engagement
Services for Students with Disabilities
100 W. Dean Keeton St. A4100
Austin, TX 78712-0175
Phone: (512) 471-6259
Fax: (512) 475-7730
VP: 512-410-6644

Attach Provider Business Card Here