



Verification of Disability (VOD)

The student named below may be eligible for accommodations and services at IVC through DSPS.

First Name: Last Name: Mi:

Student ID #: DOB: Phone #:

Name of Physician or Specialist authorized to complete the verification of disability form:

First Name: Last Name:

Phone #: Fax #:

I authorize the above physician or specialist to release information regarding my medical or health conditions and/or educational development to IVC.

Student's Signature: Date:

To be completed by Physician/Specialist:

To assist IVC's DSPS in determining reasonable educational accommodations to the student above, please complete the information below:

Diagnosis:

- Diagnosis options: Permanent, Temporary, ADHD, Autism, Intellectual Disability (ID), Acquired Brain Injury (ABI), Learning Disability, Mobility Impairment, Deaf/Hard of Hearing, Visual Impairment, Mental Health, Other.

Prescribed Medication (s) and Side Effects:

Functional limitations: the ways in which the diagnosis affects the student in the educational environment

- Functional limitations: Ability to maintain stamina, Behavior, Focus and attention, Hearing, Mobility, Oral Communication, Physical regulation, Processing information, Sitting for extended periods of time, Social communication/ social interaction, Vision, Other.

Name: Signature:

Title: License #: Date: