UNM GALLUP

# DISABILITY VERIFICATION REQUEST
## ACCESSIBILITY RESOURCE CENTER (ARC)

**Student Name:**_____ **DOB#:**_____

***NOTE: THIS FORM MUST BE COMPLETED IN FULL BY A LICENSED PROFESSIONAL.***

**Date of LAST visit:**_____

**Diagnoses (Including ICD/DSM-IV codes):** **Date:**

1._____ _____
2._____ _____
3._____ _____

**Severity:** ☐ Mild ☐ Moderate ☐ Severe ☐ Partial remission ☐ Residual state

**Condition:** ☐ Permanent ☐ Temporary (Until: _____)

**List current medications:**

| Medication | Dosage | Frequency | Patient Reported Side Effects |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Describe how the disability substantially limits major life activities:**

_____

_____

**State the impact and specific functional limitations relating to academic performance:**

_____

_____

_____

**Date of Verification:**

LICENSED PROFESSIONAL completing this form:

**PRINT NAME:** _____

**LICENSE NUMBER#:** _____

**TITLE / POSITION:** _____

**DEPARTMENT NAME:** _____

**NAME OF FACILITY:** _____

**PHONE#:** _____

**ADDRESS OF FACILITY:** _____

**SIGNATURE OF LICENSED PROFESSIONAL: X**_____

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