

University of Nevada, Las Vegas  
Disability Resource Center  
4505 S. Maryland Parkway  
Box 452015  
Las Vegas, NV 89154-2015

Phone 702-895-0866  
**FAX 702-895-0651**  
[www.unlv.edu/studentlife/drc](http://www.unlv.edu/studentlife/drc)

## Mobility Disability Verification Form

The Disability Resource Center (DRC) provides academic services and accommodations for students with diagnosed disabilities. It is the student's responsibility to provide documentation that identifies a diagnosed disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990.

DRC requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.
- Forms must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay processing and result in follow up contact with the healthcare professional.
- The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). **If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.**
- Please do not provide case notes or rating scales without a narrative that explains the results.
- In addition to the requested information, please attach any other information you think would be relevant to the student's need for academic adjustments.
- Complete the Healthcare Provider Information section on the last page and mail or fax it to the address provided above.
- If you have questions regarding this form, please call the DRC office at 702-895-0866.

*\*This document was adapted with permission from Office for Disability Services, The Ohio State University.*

**STUDENT SIGNED CONSENT FOR RELEASE OF INFORMATION**  
(Print or Type)

Name (Last, First, Middle): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ NSHE: \_\_\_\_\_

Status (check one):     Current UNLV student  
                                   Transfer student  
                                   Prospective student

Local phone: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

Cell phone: (\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_

UNLV E-Mail address: \_\_\_\_\_

Personal E-mail address: \_\_\_\_\_ (for non-admitted students)

I hereby authorize my Healthcare Provider to release information requested in this document and further authorize DRC to communicate with the named individual or agency identified below to obtain clarification as needed to determine my eligibility for disability services at UNLV. This authorization is valid for 6 months.

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

Parent Signature  
(If student is under 18): \_\_\_\_\_ Date: \_\_\_\_\_

**DIAGNOSTIC INFORMATION**  
(Please Print Legibly or Type)

*Please provide responses to the following items by typing or writing in a legible fashion. Illegible forms will delay the documentation review process for the student.*

1. What is the diagnosis, date of diagnosis, and last contact with the student?

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2. Please describe the progression of this condition if applicable.

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3. Describe the symptoms that meet the criteria for the diagnosis. Also, describe how this mobility disability may affect this student both academically and/or physically (functional limitations).

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4. List current medication(s), dosage, frequency, and adverse side effects.

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5. What **suggestions** do you have regarding accommodations, i.e. extra time for exams, notetaker, disability parking, adaptive technology. Please describe your **rationale** for accommodations you have recommended.

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6. Are there other associated conditions? If so, what are they? Please describe these conditions and any functional limitations.

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### HEALTHCARE PROVIDER INFORMATION

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Name (Print):** \_\_\_\_\_

**Title:** \_\_\_\_\_ **License or Certification #:** \_\_\_\_\_

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

**Phone Number:** (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

**FAX Number:** (\_\_\_\_)-\_\_\_\_-\_\_\_\_\_

The information you provide will *not* become part of the student's academic records, but it will be kept in the student's file at DRC, where it will be held strictly confidential. Files are purged after 7 years in compliance with state requirements. This form may be released to the student at his/her request.