

## VERIFICATION OF A TEMPORARY DISABILITY

Under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and assured services. To establish that an individual is covered under the ADA, the documentation must indicate that the disability substantially limits one or more major life activities, including learning. The following documentation requirements are provided in the interest of assuring that the documentation demonstrates a functional impact on a major life activity, is sufficient to verify eligibility, and supports the request for accommodations.

### STUDENT INFORMATION

Name: \_\_\_\_\_

UNI ID#: \_\_\_\_\_

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

Email: \_\_\_\_\_

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

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### THE FOLLOWING IS TO BE COMPLETED BY A HEALTH CARE PROFESSIONAL

1. Diagnosis, date of diagnosis, and last contact with individual:

2. Describe symptoms associated with this condition:

3. Describe how this condition currently impacts the individual in the academic environment:

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

5. Recommendations regarding accommodations (e.g., extra time for exams, housing, parking, equipment, etc.):

**HEALTH CARE PROFESSIONAL INFORMATION**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

License or Certification: \_\_\_\_\_

Area of Specialization: \_\_\_\_\_

State in which Individual Practices: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

\_\_\_\_\_  
Health Care Professional's Signature

\_\_\_\_\_  
Date

Please submit this form to:  
**Student Disability Services  
103 Student Health Center  
University of Northern Iowa  
Cedar Falls, IA 50614-0385**

OR

**(319)-273-6884 (Fax)**