UNIVERSITY OF WISCONSIN – LA CROSSE
The ACCESS Center

VERIFICATION OF
SYSTEMIC HEALTH DISABILITY

The ACCESS Center provides services to students with diagnosed systemic health disabilities. To determine eligibility for services, this office requires **current and comprehensive documentation** of the medical condition from the diagnosing **physician or health care professional currently treating the student.**

Please Print Legibly

Student Name: _____

Date Completed: ____/____/____ Student's Date of Birth: ____/____/____

1. Disability diagnosis: _____

2. Date of Diagnosis: ____/____/____

   First contact with student: ____/____/____ Last contact with student: ____/____/____

   Is the student currently under your care? _____

3. What is the severity of the condition? Please check one:

   ☐ Mild ☐ Moderate ☐ Severe

   Explain Severity: _____

   _____

   _____

4. Please describe the progression (if applicable) and expected duration of this disability.

   _____

   _____

   _____

   _____

5. Please check the major life activities/functional limitations, both physical and academic, which are impacted by the disability and the degree of severity.

	Mild	Moderate	Severe	Not an issue
Sitting				
Standing				
Walking				
Breathing				
Reaching				
Lifting				
Performing Manual Tasks				
Maintaining Stamina				
Communication: Speaking				
Communication: Writing				
Communication: Reading				
Communication: Hearing/Listening				
Seeing				
Learning				
Thinking/Reasoning				
Calculating				
Memorizing				
Cognitive Processing				
Processing Speed				
Auditory Processing				
Concentrating				
Easily Distracted				
Organization				
Meeting Deadlines				
Attending Class Regularly				
Managing Stress				
Sleeping				
Interacting with Instructors				
Interacting with Peers				
Emotional Expression				
Understanding Verbal Direction				
Other:				
Other:				

Explanation of any major life activities/functional limitations that fall into the severe range.

6. If the student is currently undergoing treatment, please describe and indicate how the treatment might affect the student academically. Please include any current medications and adverse side effects.

7. Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

8. State specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations/services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary (e.g. if a note taker is suggested, state reasons for this request related to the student's diagnosis).

9. Are there any other associated disabilities? Please describe.

Signature: _____ **Date:** _____

Print Name and Title: _____

License #: _____

Address: _____

Telephone: _____

Please send or fax this information to the address indicated below:

University of Wisconsin – La Crosse
The ACCESS Center
124 Wimberly Hall
1725 State Street
La Crosse, WI 54601
Voice: (608) 785-6900
Fax: (608) 785-6910