Disability Support Services
Verification Form for Housing Accommodations

Student Name: _____ ID#: _____

I authorize Central Texas College Disability Support Services (DSS) offices to receive information from my provider _____. I authorize my provider to discuss my condition(s) with the appropriate and qualified Central Texas College personnel on an as needed basis.

Student signature: _____ **Date:** _____

In order to determine reasonable accommodations for housing, Central Texas College requires current and comprehensive documentation of the student's condition from a licensed clinical professional or health care provider (this form must be updated yearly). ***The provider completing this form cannot be a relative of the student.*** If the space provided is not adequate, please attach a separate sheet of paper. The provider may also attach a report providing additional related information.

This form must be completed by a licensed clinical professional or health care provider familiar with the history and functional limitations of the student's condition(s).

1. Date of Initial Contact with Student: _____/_____ /_____
2. Date of Last Office Visit with Student: _____/_____ /_____
3. *Diagnosis*: Please list all relevant diagnoses. If applicable, please list all DSM-IV or ICD Diagnoses **(text and code).**

_____
_____
_____
_____

4. Approximate onset of diagnosis: _____/_____ /_____

Severity of symptoms	Prognosis of disorder:
□ mild	□ good
□ moderate	□ fair
□ severe	□ poor

5. Describe the symptoms related to the student's condition that cause significant impairment in a major life activity.

_____
_____
_____
_____
_____
_____
_____

6. Please state the specific recommendation regarding housing, and a rationale as to why these housing needs are warranted based upon the student's disability. Indicate why the change(s) to the housing environment you recommend are necessary.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for your help in providing this information. Please complete the provider information below. This form should be signed and returned via fax or mail to the DSS office at the address shown at the end of this document. All documentation submitted to DSS is considered confidential.

Provider Information

By my signature below, I certify that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature: _____ Date: _____

Print Name and Title: _____

State of License: _____

Address: _____

Phone: _____

Please return this form to:
Central Texas College
Disability Support Services
Building 215, Room 111
PO Box 1800
Killeen, Texas 76540-1800
Telephone: 254-526-1195
Fax: 254-526-1700