Provider Verification Form

Campus Accessibility Services (CAS) at Plymouth State University (PSU) facilitates academic, physical, and programmatic services and accommodations for students with documented disabilities. **Accommodations are determined on a case-by-case basis based on a review of the documentation provided and an intake meeting with a CAS staff member.** The documentation provided should:

- Establish the impairment and/or disability and date of diagnosis/diagnoses.
- Be completed by a diagnosing or treating licensed provider.
- Explain the current impact of the impairment and/or disability in a college environment, and support the need for the requested accommodations.

Campus Accessibility Services will review and consider all documentation submitted. If the documentation submitted does not support the need for the requested accommodations, further documentation may be required.

There are several ways to provide CAS with documentation of an impairment and/or a disability including:

- **A detailed evaluation or diagnostic report and plan.** Typically, these reports will include information on the student’s levels of aptitude, achievement, and information processing. These reports are recommended for students with Learning Disabilities, ADD/ADHD, and Autism Spectrum Disorder.

- **A plan that provides proof of prior accommodations.** This may also include documentation that illustrates any past use of accommodations. (This option would need to be accompanied by one of the other forms of documentation listed here.)

- **Completion of PSU’s Provider Verification Form (pages 2-4)** by a licensed provider.

- **A letter from a licensed provider.** This information should be provided on letterhead with the date and signature and provide the following information:
  - Impairment and/or disability and date of diagnosis/diagnoses.
  - Severity of the impact of the impairment and/or disability (mild, moderate, severe).
  - An assessment of major life activities that are impacted (for example: concentration, memory, social interactions, learning).
  - Recommended accommodations.
  - Include test scores when applicable.
Provider Verification Form
(Please type or print clearly)

Student’s Name_____________________________________________________________________________________

Date of Birth: _______________________
Student ID: __________________________

Address: ___________________________________________________________________________________________

Email: _______________________________ Cell Phone: __________________ Other Phone: ____________________

Diagnostic Information (To be completed by a licensed provider)

Provider Name: __________________________________________________________________________________

Provider Title: ___________________________________________________________________________________

Address: _______________________________________________________________________________________

_______________________________________________________________________________________________

Provider Phone: _______________________________ Provider Fax: _______________________________________

• Impairment(s)/Diagnosis(es) related to this request for accommodations:
_______________________________________________________________________________________________

• Date(s) of Onset (approximate)___________________________________________________________

• Severity of the Impact:  (Mild)  (Moderate)  (Severe)

Please describe any major activities impacted by the impairment(s)/diagnosis(es) or symptoms that may need to be
addressed in the college environment:
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________
_______________________________________________________________________________________________

Provider should complete pages 2-4, sign and date page 4, and include any reports with additional information. If a
comprehensive report is available providing the information requested, it can be submitted for documentation
instead of this form.
## Provider Verification Form

### Impairment in Major Life Activities:

<table>
<thead>
<tr>
<th>Life Activity</th>
<th>Unknown/Not Applicable</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
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<tbody>
<tr>
<td>Mobility</td>
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<tr>
<td>Concentration</td>
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<td>Memory</td>
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<td>Social Interactions</td>
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<td>Organization</td>
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<td>Attendance</td>
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<td>Speaking</td>
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<td>Reading</td>
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<td>Writing</td>
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<tr>
<td>Thinking (processing speed)</td>
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<td>Communicating</td>
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<td>Time Management</td>
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<td>Stress Management</td>
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<td>Managing internal distractions</td>
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<td>Eating</td>
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<td>Sleeping</td>
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<td>Self-care</td>
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Please state specific recommendations regarding accommodations for this student:

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Please describe student strengths and add any additional comments you feel are appropriate:

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Licensed Provider Signature: ___________________________ Date: ___________________________