Disability Resource Center

Disability Verification Form

University of Illinois at Chicago ("UIC") is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide reasonable accommodations, in the form of academic adjustments and auxiliary aids and services, for qualified students with documented disabilities. The purpose of reasonable accommodations is to provide equitable access to all aspects of the University's programs.

Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that any diagnosed condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

UIC's Disability Resource Center ("DRC") endeavors to provide reasonable accommodations for qualified students with documented disabilities. DRC does not modify essential elements of an instructional program or course or provide accommodations for students whose impairments do not substantially limit one or more major life activity. This form is designed to allow DRC to achieve these goals.

Students who request to receive reasonable accommodation due to disability must have this form completed by a certified physician or medical professional. The certified physician or medical professional completing this form must have first-hand knowledge of the student's condition and must have experience diagnosing and treating college students.

Section I: Student Information (*to be completed by the student*)

Last Name:	First Name:	Middle Initial:
UIN:	Date of Birth:	
Phone Number:	Email Address:	

Section II: Medical Information (*to be completed by Certifying Physician or Medical Professional*)

Certifying Physician or Medical Professional	
Name:	
Credentials / Specialty:	
Address:	
Phone Number:	Email Address:

Disability Resource Center

Section II: Medical Information (*to be completed by Certifying Physician or Medical Professional*)

Treatment Record	
Diagnosis:	
Initial Date of Diagnosis:	Most Recent Appointment:
Side Effects of Current Medications (if applicable)	

Limitations Due to Disability
Limitations on learning abilities in higher education environment (e.g. difficulty in concentration/organization, difficulty managing distractions, lapses in memory, etc.)
Limitations on exams and classroom activities in higher education environment (e.g. attendance, taking exams, completing assignments, etc.)
Limitations on non-academic activities in higher education environment (e.g. parking, housing, mobility, etc.)

Disability Resource Center

Section III: Recommended Accommodations

(*to be completed by Certifying Physician or Medical Professional*)

Each suggested or recommended accommodation should include a detailed explanation of its relevance to the diagnosed disability. *Final determination of appropriate accommodations will be determined by UIC's Disability Resource Center in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.*

If you have any questions regarding this form, please call the Disability Resource Center at 312-413-2183, Monday through Friday from 8:30 a.m. to 5:00 p.m. Central Time.

Please upload this form by clicking on our Protected Health Information (PHI) link here or visiting https://uofi.app.box.com/f/aa44b4d6733a43a1a0f56b9a9c366db6.

We are currently working remotely and therefore, faxes are viewable via email and may not be as easily accessible so please keep this in mind when submitting documentation.

This document may not be released without written permission from the student or in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA).

Signature of Certifying Physician or Medical Professional

Date