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 disability from a licensed clinical professional or health care provider (this form must be updated yearly by the student). ***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).

Providers who do NOT have an established treatment history with the patient should NOT complete this form.

PLEASE PRINT INFORMATION BELOW - forms that are illegible will not be accepted by CTC.

1. Date of Initial Contact with Student: _____/_____ /_____
2. Date of Last Office Visit with Student: _____/_____ /_____
3. Does the student have a physical or mental impairment that qualifies as a disability under the Americans with Disabilities Act? Yes or No _____
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(s) 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. 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 and am qualified to do so.

Signature: _____ Date: _____

Print Name:

Title/Specialty: _____

State of License and License Number: _____

Address: _____

Phone: _____

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