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:** _____

To arrange appropriate housing accommodations, Central Texas College needs current and complete documentation of the student's condition from a licensed clinical professional or healthcare provider. This form must be renewed annually. The provider completing it should not be a relative of the student.

If the space provided is insufficient, attach additional sheets. The provider can also include a report with more relevant information. This form should be filled out by a professional familiar with the student's condition and limitations.

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 reason 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.

_____

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Thank you for providing this information. Please fill in the provider details below. Sign and return the form via fax or mail to the DSS office at the address listed at the end of this document. All information submitted to DSS is treated as 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 email or return this form to:
Central Texas College
Disability Support Services
PO Box 1800
Building 215, Room 111
Killeen, Texas 76540-1800
Fax: 254-526-1700
Email: cshank@ctcd.edu