



# Verification of Disability Form

## Physical, Psychological, Sensory, and Other Medical Disorders

**Sheridan Technical College (Main)**  
5400 Sheridan Street  
Hollywood, FL 33021  
Tel: 754.321.5400/ Fax: 754.321.5518

**Sheridan Technical College (West)**  
20251 Stirling Road  
Pembroke Pines, FL 33332  
Tel: 754-321-3900

**Directions:** Form must be completed by the appropriate qualified medical professional. Please attach any available documentation to support diagnosis.

Student Name: \_\_\_\_\_ Student ID: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Diagnosis Code (from DSM-V): \_\_\_\_\_

**IMPACT OF DISABILITY:** What are the current functional limitations of the student of learning and/or performing effectively in an educational setting?

\_\_\_\_\_  
\_\_\_\_\_

Is this individual a danger to him/herself or others?  Yes  No

Please state any relevant behavioral observations: \_\_\_\_\_

**MEDICATIONS:** Please list any medication(s) the student is currently taking the side effect(s) the medication(s) may have on learning such as: concentration, focusing, attention, etc.

<b>Medication(s):</b>	<b>Side Affect(s):</b>
_____	_____
_____	_____

**ACCOMMODATIONS RECOMMENDED:** Please state any recommendations for reasonable accommodations needed by the student. Examples of **specific** recommendations may include: "50% extra time", "small group testing (11-16)", etc. **Non-specific** recommendations such as "extra time" or "unlimited time" are **not acceptable**. Please remember, **the provision of reasonable accommodations must be based on objective evidence of a substantial limitation to learning and must be supported by test results, clinical observations, etc.** Accommodations are not given to ensure the student has plenty of time to finish test/assignment.

- |          |          |
|----------|----------|
| 1. _____ | 3. _____ |
| 2. _____ | 4. _____ |

**Diagnostician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

Physician's office stamp here

For questions, please contact:  
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