Disability Services and Programs

Disability Verification: Deaf/Hard-of-Hearing

Student Name: ___________________________ Birthdate: ____________

Waiver: I am requesting academic accommodations through Disability Services & Programs (DSP) at the University of Southern California. The University requires current and comprehensive documentation of my disability as one of the criteria used to evaluate my eligibility for disability-related accommodations and services.

In order to provide the required documentation, I give my permission for you to complete this form on my behalf, and return it as soon as possible to me, or directly to the DSP by fax (213-740-8216) or email (ability@usc.edu).

Additionally, I authorize staff at DSP to contact you if clarification about the information you provide is needed.

Student Signature: ___________________________ Date: ____________

Health Care Provider Name: ___________________________
Title: ____________________________
Specialty: ____________________________
Phone: ____________________________
Organization & Address: ____________________________

This Verification form should be completed as thoroughly as possible by a qualified healthcare professional, who is not related to the student. A qualified professional for someone who is deaf or hard-of-hearing should be an otolaryngologist, audiologist, speech and hearing specialist, or other qualified professional who is familiar with the student’s hearing loss.

USC uses a multi-source process to determine student’s eligibility for disability-related accommodations, including student self-report, history of accommodations (when it exists), diagnostic information and outcomes, and clinician observation. Information about how this individual student is impacted deafness or hearing loss is carefully considered as part of the process of determining reasonable accommodations.

We appreciate your thorough and thoughtful response to the questions on this form. If you have questions about this form or how the information is used, we invite you to contact us at 213-740-0776.

Updated: 12/2017
The remainder of this form should be completed and then signed and dated by the Healthcare Professional listed on page 1.

Please note: If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

### Student Information:

Student (Client) Name: ________________________________

Date of birth: ________________  USC ID#: __________________

### Diagnostic Information

1. Please list the diagnosis/es and the relevant ICD-9 or ICD-10 codes.

2. Original date of diagnosis/es: ________________

3. Age of individual when first diagnosed: _____________

4. Contact with student
   - Date of first contact with student (mm/dd/yyyy): ____________________
   - Date of most recent contact with student (mm/dd/yyyy): ________________
   - Please describe the frequency of your contact with this student/client:

5. Is the condition:
   - ___ Temporary (six months or less)
   - ___ Unchanging/permanent
   - ___ Likely to progress

   Please explain the prognosis:
6. Assessment of hearing loss

- Degree of hearing loss? ________________________________
- Level of hearing loss? ________________________________
- Bilateral or unilateral? ________________________________

7. What method was utilized to determine hearing loss? If audiogram is available, please include with this form.

8. Please describe any pertinent history about this student/client:

9. Does the individual currently use or have a history of using any of the following?

__ Hearing aids
__ Cochlear implant
__ Assistive listening device
__ CART
__ Sign language interpreters
__ Service animal to accommodate hearing loss
__ Other (please specify):
Functional Limitation Information

According to the ADAAA (2008), disability is defined as an impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, speaking, learning, reading, concentrating, thinking, communicating and working.

Accommodations for this student/client will be determined based on this legal guideline. In order to provide a thorough picture of the functional limitations experienced by your student/client, please take time to thoroughly describe any functional limitations in the section below. Please include copies of assessment instruments, if they exist, that provide evidence of the functional limitations.

10. Please describe how the hearing loss may affect how this individual learns and interacts in the classroom setting. Specifically address areas such as speaking, participation in class or group discussions, and processing information.

11. Please describe how the hearing loss may affect this individual with completing coursework and tests (reading, writing, spelling, meeting deadlines, etc.).

12. Please describe how the hearing loss may affect this individual in social settings.

13. Other relevant information:
Accommodation Information

Accommodations are not based on the student’s diagnosis, but instead are designed to address the barrier(s) caused by any functional limitation(s) related to the condition. Accommodations are meant to allow for equal access to academic and university life for students with disabilities; they do not guarantee student success.

14. Please indicate below your recommendations for accommodations within the post-secondary environment, as supported by the reported functional limitations and their impact on this student. Also include any housing accommodations.

Accommodation: 
Rationale: 

Accommodation: 
Rationale: 

Accommodation: 
Rationale: 

Clinician Information (to be completed and signed by the licensed clinician who completed this form)

Date: ________________
Clinician Name (print): ____________________________________________
Clinician Signature: ________________________________________________
License Type and #: ________________________________________________
Clinic or Organization: _____________________________________________
Address: __________________________________________________________
Phone: ___________________________ Email: ___________________________