Disability Verification: Post-Concussion/Traumatic Brain Injury

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 medical condition 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, treating healthcare professional, who is not related to the student.

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 clinical assessment. Information about how this individual student is impacted by their condition 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**.

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 (Patient) Name: _____

Date of birth: _____ USC ID#: _____

Diagnostic Information

1. Please list the diagnosis/es:

    - Dates of injury(ies): _____
    - Loss of consciousness at the time of injury?

2. Contact with student:
    - Date of first contact with student/patient (mm/dd/yyyy): _____
    - Date of most recent contact with student/patient (mm/dd/yyyy): _____

3. Please describe the frequency of your contact with this student/patient:

4. Severity of the diagnosis: ☐ *mild* ☐ *moderate* ☐ *severe*

5. Current status of the Condition(s) (e.g. Active, Progressing, Episodic, Controlled, In Remission)

6. Prognosis: How long is this condition(s) likely to persist? (please be as specific as possible, e.g. lifetime, academic year, one month, etc)

7. Please list procedures/assessments used to diagnose this student's condition:
   (please attach any assessments conducted related to a student's learning processes, attention, or cognition)

8. How does this condition impact the student currently? Please include current symptoms (ie physical, emotional, cognitive, and sleep) as well as explanation of any side effects from medication the student may be taking.

9. What factors exacerbate the impact(s) of the student's condition? Please include any academic restrictions with as much specificity as possible (e.g. screen use limited to 20 min at a time, concentration tolerance of 15 min prior to symptom onset, can read text on paper but not computer):

10. What, if any, other diagnoses are co-existing that may compound the impact of the condition or diagnosis?

11. Please describe any pertinent history about this student (including any prior history of concussions):

12. Please describe the current treatment plan for this student/patient:

13. Other relevant information:

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, those listed in the chart below. 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 indicate the frequency/duration as well as the severity of each item below. *Please include copies of any assessment instruments used that provide evidence of the functional limitations.*

14. Please rate the frequency/duration and severity (using "x") of the condition's impact on major daily life activities to the best of your knowledge. For comparison purposes, please use same age peers in a post-secondary setting.

Major Life Activity	**Frequency/ Duration 0-4 scale***	**Severity**			
		Mild	**Moderate**	**Severe**	**Unknown or N/A**
Bending					
Balance					
Computer use					
Concentration					
Eating					
Emotional Regulation					
Hearing					
Hygiene / Self-Care					
Impulse Control					
Initiating Activities					
Interacting with Others					
Lifting/Carrying					
Manual Tasks					
Memory					
Sitting					
Speaking					
Sleeping					
Use of Transportation					
Vision					
Walking / Standing					
Learning (pls also rate the following activities)					

Major Life Activity	Frequency/ Duration 0-4 scale*	Severity			
		Mild	Moderate	Severe	Unknown or N/A
Attending Class					
Following Directions					
Managing Distractions					
Meeting Deadlines					
Persistence					
Processing Speed					
Organizational Skills					
Reading					
Writing					
Other: please specify					

**Frequency/Duration Scale: 0=never, 1=rarely, 2=intermittent, 3=daily/frequently, 4=chronic*

Accommodation Information

A diagnosis of a particular condition does not, in and of itself, qualify a student for accommodations under the ADAAA. 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.

15. Please indicate your recommendations for accommodations within the post-secondary environment, as supported by the reported functional limitations and their impact on this student. Please attach a separate sheet for additional recommendations.

    Accommodation:
    Rationale:

    Accommodation:
    Rationale:

    Accommodation:
    Rationale:

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

Date: _____

Clinician Name (print): _____

Clinician Signature: _____

License Type and #: _____

Clinic or Organization: _____

Address: _____

Phone: _____ Email: _____

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