WHITMAN COLLEGE

Academic Resource Center

Disability Support Services: Academic Resource Center
Whitman College
345 Boyer Avenue
Walla Walla WA, 99362
Fax: 509-527-5039
Email: dss@whitman.edu

Provider Verification of Disability Form

In order for Disability Support Services (DSS) at Whitman College to provide appropriate academic and housing accommodations and services, we need to establish that this individual has a disability that limits one or more of their major life activities. Information provided on this form is only used to assist DSS in determining if this student's physical or mental health condition is a disability and what accommodations may be appropriate. For DSS' full documentation guidelines, please visit https://www.whitman.edu/academics/disability-support-services.

Once the form has been completed, it should be submitted to DSS. It can either be uploaded by the student into their Accommodate profile or returned directly to DSS at the fax or email address above by the student or provider.

Note: Please attach a copy of any supportive report or test results that would be helpful in determining eligibility and appropriate services.

Patient Information

Today's Date: Date of Last Appointment: Patient's DOB:

Patient's Name: _____ _____ _____

Last First MI

Disability/Diagnosis with DSM-5 Code:

Level of Severity: ☐ Mild ☐ Moderate ☐ Severe

Quality of Life: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Duration of disability: ☐ Permanent ☐ Temporary Until Date:

Do the symptoms of the diagnosis/diagnoses need to be reevaluated on a regular basis? If yes, how often?

Please describe any current symptoms of the stated diagnosis/diagnoses this student experiences.

If the student experiences episodic flare-ups of their condition please describe any triggers of episodes, the frequency and duration of episodes, and care plan for management/recovery from the episode.

How does the diagnosis/diagnoses significantly affect the student's performance in academic settings?

Please describe any prescribed medications, their side effects, and/or any potential impact the medications may have on academic performance.

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Functional Limitations

Please check the level of limitation you believe this student experiences in the college environment as a result of their disability. Check only those boxes that apply.

1: Slightly Limited 2: Moderately Limited 3: Substantially Limited

	1	2	3
Caring for Oneself	☐	☐	☐
Talking	☐	☐	☐
Hearing	☐	☐	☐
Breathing	☐	☐	☐
Seeing	☐	☐	☐
Walking/Standing	☐	☐	☐
Sitting	☐	☐	☐
Performing Manual Tasks	☐	☐	☐
Eating	☐	☐	☐
Working	☐	☐	☐
Interacting with Others	☐	☐	☐
Sleeping	☐	☐	☐
Reading	☐	☐	☐

	1	2	3
Writing	☐	☐	☐
Spelling	☐	☐	☐
Quantitative Reasoning	☐	☐	☐
Math Calculating	☐	☐	☐
Processing Speed	☐	☐	☐
Memorizing	☐	☐	☐
Concentrating	☐	☐	☐
Listening	☐	☐	☐
Executive Functioning	☐	☐	☐
Other (ex: Scheduling/Organizing)			
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

Additional Comments: Is there anything else we should know about this student (e.g., time-of-day needs, use of assistive mobility device, suggested accommodations)?

Provider Information

Note: The documentation must be from an individual who is qualified by education and experience to diagnose the specific disability. The diagnosing professional must have expertise in the differential diagnosis of the documented disability, must follow established best practices in the field, and must not be related to the patient.

Provider Name: License Number:

Signature:

Address:

Phone: Fax: Email:

If the student needs housing related accommodations, please fill out the Housing Documentation Form

Last Updated: 03/18/25