NORTHEAST
WI Technical College

Disability Services Office, SC229 | 2740 West Mason St, Green Bay, WI 54303 | 920-498-6904 | Fax: 920-491-3792
disability.services@nwtc.edu

DISABILITY VERIFICATION

(To be completed by a licensed physician, psychiatrist, psychologist, counselor, or social worker)

Student Name: _____ D/O/B: _____

(Please type or print neatly / use a separate paper if needed)

1. What is the diagnosis? _____
2. When was the diagnosis made? _____
3. Nature of diagnosis: Acute_____ Episodic _____ Chronic _____ In Remission _____
4. Level of severity: Mild _____ Moderate _____ Severe _____
5. When was your last contact with the above-named student? _____
6. Is the condition: Temporary (< 6 months) _____ Permanent _____ Unsure _____
   - If temporary or unsure, how long do you anticipate this students' academic performance may be impacted by their disability? _____
7. Please provide an explanation of the disability, medical condition, or symptoms when in active state, including frequency and duration, if applicable: _____

   _____
8. If a treatment plan exists, what is the plan in brief and how might it affect the student academically?

   _____

   _____
9. Functional limitations(s)/impact(s) caused by this disability, or treatment, on daily living:

   _____

   _____
10. Recommendations for disability management within the post-secondary school setting (must be clearly linked to functional limitations/impact), if any: _____

    _____
11. Are there any other factors or information you think would be helpful in determining academic accommodations for this student? _____

    _____

Professional's Signature: _____ License #: _____

Name and title: _____

Clinic/Agency Name: _____

Address: _____

Phone: _____ Date: _____