UCNJ Union College of Union County, NJ

1033 Springfield Avenue • Cranford, NJ 07016
40 West Jersey Street • Elizabeth, NJ 07202
232 East Second Street • Plainfield, NJ 07060
1776 Raritan Road • Scotch Plains, NJ 07076
908.709.7000 www.ucc.edu

Universal Accessibility Services
1033 Springfield Avenue SD-115
Cranford, NJ 07016
Phone- 908-709-7164
disabilitysvc@ucc.edu

UCNJ Disability Verification Form

Universal Accessibility Services provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrist, speech-language pathologist, etc.) in obtaining the specific information to evaluate eligibility for academic accommodations.

A. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnosis medical conditions.

B. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

C. **The healthcare provider should attach any reports which provide additional related information** (e.g. psychological/educational assessments, neuropsychological test results, Individualized Education Programs [IEPs], etc.). If a comprehensive diagnostic report/evaluation is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

D. **The information you provide will be kept in the student's file in the Universal Accessibility Office on the Cranford campus, where it will be held securely and confidentially. This form may be released to the student at their request.**

If you have questions regarding this form, please call Universal Accessibility Services at 908-709-7164.

Updated 08-30-2023.

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STUDENT INFORMATION

(Please Print Legibly or Type)

First Name ______________________ **Middle** ________________ **Last** ___________________________

Date of Birth _______________________________ **Student ID#** ______________________________

Status (check one) ☐ **current student** ☐ **transfer student** ☐ **former student**

Local phone (_______) -________-_____________ **Cell phone** (_______) -________- _____________

Address ____

____

____

UCNJ email email address: ____

Other email address: ____

Important: After documentation is reviewed, Universal Accessibility Services will send an email notification to the student's UCNJ email acknowledging receipt of documentation and the student's eligibility status.

DIAGNOSTIC INFORMATION

(Please print legibly or type)

1. Date of Diagnosis: ____

2. Primary Diagnosis: ____

   Secondary Diagnosis: ____

3. What is the severity of the disorder? ☐ **Mild** ☐ **Moderate** ☐ **Severe**

4. Please state the medication or treatment the student is currently prescribed:

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5. Major Life Activities Assessment: *Please check each of the following major life activities that are impacted by the disability. Indicate severity of limitations.*

Life Activity	Negligible	Moderate	Substantial	Not Sure
Concentrating	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Eating	☐	☐	☐	☐
Social Interactions	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐
Regular Class Attendance	☐	☐	☐	☐
Speaking	☐	☐	☐	☐
Learning	☐	☐	☐	☐
Reading	☐	☐	☐	☐
Thinking	☐	☐	☐	☐
Communicating	☐	☐	☐	☐
Keeping appointments	☐	☐	☐	☐
Stress Management	☐	☐	☐	☐
Managing internal distractions	☐	☐	☐	☐
Managing external distractions	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐
Organization	☐	☐	☐	☐

6. In addition to the major life activities that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:

7. Please state specific recommendations regarding academic accommodations for this student:

8. Please add any additional comments that you feel appropriate:

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HEALTHCARE PROVIDER INFORMATION

(Please sign and date below and completely fill in all other fields using PRINT or TYPE)

Provider Signature____

Date ______________

Provider Name (print)____

Title ____

License or Certification # _______________________________________

Address ____

Phone Number (________) -_________- _____________