



UNIVERSITY of NORTH CAROLINA WILMINGTON

DISABILITY RESOURCE CENTER

# STUDENT CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION WITH CERTIFYING PROFESSIONAL

## To the UNCW Student Requesting Services:

The Disability Resource Center (DRC) provides accommodations to students diagnosed with a disability that substantially limits one or more major life activity. The University has an obligation to confirm students receiving accommodations have verified disabilities.

To determine eligibility for services and appropriate accommodations, current and comprehensive documentation of the disability from a licensed professional who is credentialed to perform such evaluation is required.

The DRC is committed to ensuring all information regarding a student is maintained confidentially as required or permitted by law.

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I, (Student Print Name) \_\_\_\_\_, hereby authorize the release and exchange of the following information to the **Disability Resource Center (DRC) at the University of North Carolina Wilmington** for the purpose of determining eligibility for educational accommodations. If additional information is necessary, I give permission for the DRC staff to contact the Certifying Professional of this form to discuss my documentation and relevant disability-related information.

This authorization expires four years from the date indicated below, or upon graduation from UNCW, whichever comes first. However, I understand that I have the right to revoke this consent in writing at any time.

\_\_\_\_\_  
Student Signature\*

\_\_\_\_\_  
UNCW 850#

\_\_\_\_\_  
UNCW Email

\_\_\_\_\_  
Today's Date

\*If the information above is left blank or is incomplete, it may delay or prevent the DRC from contacting you to verify receipt of the documentation and provide next steps for completing the enrollment process.

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601 S. COLLEGE ROAD • WILMINGTON, NORTH CAROLINA 28403-5942 • TEL 910.962.7555 • FAX 910.962.7556 • EMAIL [DRC@UNCW.EDU](mailto:DRC@UNCW.EDU)



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## VERIFICATION OF DISABILITY

### To the Certifying Professional:

The student named above has begun the process of requesting services with the Disability Resource Center (DRC) at University of North Carolina Wilmington. To determine eligibility and provide services, we require documentation of the student's disability.

Under the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments. Should documentation be provided that the DRC finds to be inadequate to support the requested accommodations, the DRC will let the student know what additional documentation is necessary.

We ask that you complete this form in its entirety, providing complete answers for all questions. If you are unable to provide a response for a question, please indicate the reason. Provide responses by typing or writing clearly, as illegible forms will delay the documentation review process for the student. If you feel additional information beyond this verification form is needed to provide a more complete understanding of the student's request, you are welcome to submit additional documentation.

Upon completion, please submit the form directly to the Disability Resource Center by email ([drc@uncw.edu](mailto:drc@uncw.edu)) or fax (910.962.7556). The information you provide will not become part of the student's educational records. It will be kept in the student's file in the DRC, where it will be held strictly confidential. This form may be released to the student at their request.

Please do not hesitate to contact our office with any questions or concerns. Your assistance with providing verification of the student's disability is greatly appreciated.

Sincerely,

The Disability Resource Center  
University of North Carolina Wilmington

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## VERIFICATION OF DISABILITY

### TREATING PROVIDER MUST COMPLETE THE FOLLOWING:

- Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_\_
- What is your diagnosis for this student? (Include DSM-V diagnostic codes, if applicable)
  - Primary: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
  - Secondary: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
  - Tertiary: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
  - Other: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_
- Is the student currently under your care?  Yes  No
- Date Last Seen: \_\_\_\_\_
- Based on your subjective opinion, how well do you know the student?
  - Very Well  Moderately Well  Not Well at All
- How did you arrive at your diagnosis?
 

Please check all relevant items below. Add brief notes you believe may be helpful in determining which accommodations and services are appropriate for the student.

<input type="checkbox"/> Structured/Unstructured Interviews with Student	<input type="checkbox"/> Neuropsychological Testing (Date of Testing: _____)
<input type="checkbox"/> Interviews with Other Persons	<input type="checkbox"/> Psychoeducational Testing (Date of Testing: _____)
<input type="checkbox"/> Behavioral Observations	<input type="checkbox"/> Standardized/Non-Standardized Rating Scales (Date of Testing: _____)
<input type="checkbox"/> Developmental History	<input type="checkbox"/> Other, please specify: _____
<input type="checkbox"/> Educational History	
<input type="checkbox"/> Medical History	
- Is the student receiving treatment, therapy, or taking medication(s) for this condition(s)?  Yes  No  
If yes, please list medication(s), dosage(s), and any current treatment(s) or therapy the student is receiving:



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8. Does the student's condition substantially limit one or more major life activities?  Yes  No

9. Expected duration of condition:

Permanent/Chronic

Short-Term (60-90 days)

Long-Term (3-12 months)

Temporary (60 days or less)

10. Please state the student's functional limitations based on the symptoms/manifestations of the disability:

11. Please list any specific accommodations you recommend for this student based upon the functional limitations:

12. Optional: You may use the space below, or additional pages as needed, to provide any other information you believe will be helpful to DRC staff in considering the accommodations you are recommending.

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**Certifying Professional\***

I, the undersigned, certify that the information provided for the aforementioned student is true and correct to the best of my knowledge and reflects my responses to the questions. I confirm that I am licensed or otherwise qualified to diagnose the conditions listed above, have adequately evaluated the student, can produce record of such evaluation, and are not related to the student by blood or marriage.

\_\_\_\_\_  
Treating Provider Signature (if in training, please include supervisor's signature)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Name (please print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
License No.

\_\_\_\_\_  
State of Licensure

\_\_\_\_\_  
Name of Agency/Office

\_\_\_\_\_  
Phone Number (including area code)

\_\_\_\_\_  
Agency/Office Street Address

\_\_\_\_\_  
Fax Number (including area code)

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Email

\*Qualified diagnosing professionals are licensed medical providers, psychologists, psychiatrists, neurologists, clinical social workers, and counselors. The diagnosing professional must have expertise in the differential diagnosis of the documented disorder(s) or condition(s) and follow established practices in the field.

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