EC-Council | University

Diagnosis Verification Request

Student Name:_____ DOB#: _____

This part of the form is to be completed by the student:

Describe how the disability substantially limits your major life activities:

_____

_____

State the impact and specific functional limitations relating to your academic performance: _____

_____

_____

_____

This part of the form is to be completed in full by a licensed professional:

Diagnoses (Including ICD/DSM-IV codes): Date:

1._____ _____

2._____ _____

3._____ _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Partial remission ☐ Residual state

Condition: ☐ Permanent ☐ Temporary until _____

Date of last visit:_____

Continue to second page.

List current medications:

Medication	Dosage	Frequency	Patient Reported Side Effects

Practitioner Comment (if applicable): _____

_____

_____ _____

Signature of Licensed Professional Date of Verification

_____ _____

Print Name/Title License Number

_____ _____

Address Phone Number