WENATCHEE VALLEY COLLEGE

SAS Verification Form for Healthcare Provider

Instructions

The information provided on this form will be used by Student Access Services (SAS) at Wenatchee Valley College to determine a student's eligibility for reasonable accommodation. This information will also supplement the student's narrative regarding the impact of their condition(s) and provide valuable insight regarding appropriate accommodations for the student. When able, please provide thorough and legible information regarding the educational impact of the student's disability(ies).

This form should be completed by a professional who is qualified to diagnose and treat the condition(s) stated on this form. If the certifying professional completing this form did not make the diagnosis, please provide information for the original diagnostician as well. This form should not be used for learning disabilities. For full documentation guidelines, please visit https://www.wvc.edu/students/support/disability-services/documentation-guidelines.html

How to Submit This Form

This completed form should be returned to SAS by the student or the healthcare provider. The student may upload the completed form with their Student Access application, or with the documentation link provided in the student's application confirmation email.

Alternatively, the student or healthcare provider may return the form directly to SAS with any of the contact information below:

Student Access Services
Wenatchee Valley College
1300 Fifth Street
Wenatchee, WA 98801

Phone: 509-682-6854
Fax: 509-682-6811
Email: sas@wvc.edu

Student Information (this section is to be completed by the student)		
Name	SID	Date of Birth

Healthcare Provider Information (this section is to be completed by the healthcare professional)		
Name	Credentials & Licensing Info	
Address		
City	ST	ZIP
Phone	Email	

Diagnosis made by (if someone other than certifying professional completing this form)		
Name	Title	
Address		
City	ST	ZIP
Phone (if known)	Email (if known)	

Disability Assessment

(this section is to be completed by the healthcare professional)

1. Please state the specific diagnosis(es)/health condition(s)

2. Date of diagnosis/testing

3. Diagnostic methodology used

4. Please describe the symptoms of the diagnosis(es)

5. The disability(ies) is/are best described as: (select from the list below)

   Permanent and chronic/continuous

   Permanent and episodic

   Please describe any known triggers, the frequency and duration of flare-ups, the care management/recovery of an episode.

   Temporary

   What is the expected duration of the condition? Will the symptoms of the diagnosis(es) need to be reevaluated? If yes, how often?

6. Please describe any side effects from medication or treatment that may affect the student's academic functioning.
7. How might the diagnosis(es) affect the student's academics?

Impact on major life activities: Please check all that apply

Activity	**Mild**	**Mod.**	**Severe**	**Other**	
Breathing				Chronic Pain	Easily Fatigued
Paying Attention				Anxiety	Agoraphobia
Interacting				Panic Attacks	Impulsive
Info Processing				Easily Overwhelmed	Easily Distracted
Reading					
Memory				**Other Comments**	
Self-Care					
Sitting					
Standing/ Walking					
Speaking					
Fine motor skills/ Writing					
Hearing db loss	left:	right:			
Vision Visual Acuity Field	 left: left:	 right: right:			

Thank you for taking the time to fill out this form. Your answers will assist us to better accommodate the student.

By signing below, I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Signature of Healthcare Provider: ______________________________ Date: ____________