UNM GALLUP
ACCESSIBILITY RESOURCE CENTER

Diagnosis Verification Request

PERSONAL INFORMATION:

Student Name:_____ DOB#: _____

Banner ID #: _____ UNM Net ID (E-mail): _____@unm.edu

Gender Identification: _____

Address (Permanent): _____ City _____ State: ___ Zip: _____

Phone: _____ Cell: _____

What is the best way to reach you? ☐ Cell ☐ Home ☐ Email

Emergency Contact Information:
Name: _____ Relationship to you _____ Phone: _____

How did you find out about ARC?

☐ Faculty Name:_____ ☐ Internet Site: _____
☐ Staff Name: _____ ☐Agency Name: _____
☐ Student/Friend ☐Other: _____

Describe how the disability substantially limits your major life activities:

_____

_____

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

_____

_____

_____

NM GALLUP
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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 of Condition: ☐Mild ☐Moderate ☐Severe ☐Partial Remission ☐Residual State

Condition: ○ Permanent ○ Temporary until _____

What is the date of your last visit?: _____

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