



**DISABILITY VERIFICATION**  
**Deaf/Hearing**

*Please read the following prior to completing this form:*

Student Accessibility Services at Kent State University provides support services to students with diagnosed disabilities, including deafness and other hearing disabilities. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires **comprehensive, and depending on the specific disability, current documentation of the disorder from their diagnosing/current physician or audiologist.** This should include information that describes the symptoms and manifestation of the condition, medication prescribed, and recommendations for treatment. **A copy of the student's most recent audiogram is also required.**

*\*NOTE: Student Accessibility Services (SAS) reserves the right to make appropriate modifications to the above time frame required for current documentation when necessary.*

For additional information about SAS please visit: [www.kent.edu/sas](http://www.kent.edu/sas)

Please provide the following information about (student name): \_\_\_\_\_

1. Diagnosis: \_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_ Last contact with student: \_\_\_\_\_

Is the student/patient currently under your care? \_\_\_\_\_ YES \_\_\_\_\_ NO

2. Please describe the **student's degree of hearing loss**: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Describe the **student's prognosis** for this condition: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please describe **assistive listening devices or auxiliary aides** the student is currently using: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Describe the **primary method of communication** for the student: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List **current medication(s), dosage, frequency and possible adverse side effects** as related to academic performance, if applicable: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. List any **recommendations for accommodations** you have for this student in an academic setting:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Please describe any specific concerns you may have, or other ways that we may be of further assistance to this student/patient: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Healthcare Provider Information**

Provider Name and Title: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

The information you provide in this document is maintained in the office of Student Accessibility Services at Kent State University according to the guidelines of the Family Educational Rights and Privacy Act (FERPA).

**Please mail or fax this completed form to:**

Student Accessibility Services • Kent State University • Ground Floor, DeWeese Center • Kent, OH 44242  
**Phone:** (330) 672-3391 **Fax:** (330) 672-3763 **Email:** sas@kent.edu