

Disability Services

Verification of Temporary Disability Form

Name of Patient: _____

Date: _____

Vancouver Island University requires that Disability Services verify a student's disability, injury, or illness in order to provide support services. The above named individual has requested services due to a temporary disability. Based on your knowledge of the student's condition, please indicate on this form the nature of the disability, anticipated duration, and the services that would be most appropriate.

Anticipated Duration of Services: _____

DISABILITY: Mobility Visual Hearing

Other (please specify) _____

SERVICES: Accommodated Exams

Note-taker

Other (please specify) _____

PHYSICIAN NAME: _____

ADDRESS : _____

PHYSICIAN SIGNATURE: _____