FLORIDA ATLANTIC UNIVERSITY

RELEASE OF INFORMATION
FOR VERIFICATION OF HEARING LOSS

Student will complete this page and provide it to their clinician. The clinician will complete the verification form.

I, _____, herby authorize the release of the following information as well as any pertinent documentation to the Student Accessibility Services at Florida Atlantic University for the purpose of determining my eligibility for accommodations.

Student's Signature _____ Phone: _____

Student's Z# _____ Date of Birth: _____

Check the applicable box below to determine how SAS will receive the verification form:

☐ Please return the completed verification form to client/student.

☐ Please return the completed verification form to the Student Accessibility Services office:

☐ Florida Atlantic University- Boca Campus
Student Accessibility Services
777 Glades Road, SU 133
Boca Raton, FL 33431
tel: 561.297.3880 fax: 561.297.2184

☐ Florida Atlantic University- Jupiter Campus
Student Accessibility Services
5353 Parkside Drive, SR 111F
Jupiter, FL 33458
tel: 561.799.8585 fax: 561.799.8819

FLORIDA ATLANTIC UNIVERSITY

STUDENT ACCESSIBILITY SERVICES
VERIFICATION OF HEARING LOSS

This form should be completed **ONLY** by the Clinician.

***Important*:** *Please note, changing an existing document after it has been signed, faking a signature, or making a false document are all considered to be a forgery.*

CLINICIAN NAME (PRINTED): _____

SIGNATURE OF CLINICIAN: _____

CREDENTIALS: _____ SPECIALTY: _____

LICENSE/CERT. #: _____ STATE_____

DATE: _____

My signature verifies that I am or have been this student's treating health care professional and that all the contents below are true and accurate.

Patient's Name: _____

Date of Most Recent Examination: _____

1. Diagnosis: Right Ear _____ Left Ear _____
2. Etiology: Right Ear _____ Left Ear _____
3. Prognosis: Permanent ☐ Temporary ☐ How long? ____
4. Degree of Hearing Loss: Right Ear _____ Left Ear _____
5. Type of Hearing Loss: Right Ear _____ Left Ear _____
6. Use of Hearing Aid: Right Ear _____ Left Ear _____

****Please attach an audiogram along with a written narrative defining the hearing loss.**

7. Is the student on any medication that may affect attention, concentration, or any other facet of learning or living environment? Yes ☐ No ☐

   Medication: _____

Side Effects: _____

8. Describe in detail the student's functional limitations associated with this diagnosis. How might this disability impact the student academically?

   _____

   _____

   _____

9. Are there any specific academic accommodations you would recommend for this student?

   _____

   _____

   _____