Disability Support Services

 1033 Springfield Avenue Room SD-115

Cranford, NJ 07016

Phone- 908-709-7164

disabilitysvc@ucc.edu

# Disability Verification Form

The Office of Services for Students with Disabilities provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities.

The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional (psychiatrist, psychologist, counselor, therapist, social worker, medical doctor, optometrist, speech-language pathologist, etc.) in obtaining the specific information to evaluate eligibility for academic accommodations.

1. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified, or licensed to diagnosis medical conditions.
2. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

# The healthcare provider should attach any reports which provide additional related information

(e.g. psychological/educational assessments, neuropsychological test results, Individualized Education Programs [IEPs], etc.). If a comprehensive diagnostic report/evaluation is available that provides the requested information, copies of that report can be submitted for documentation in lieu of this form. In addition to the requested information, please attach any other information you think would be relevant to the student’s academic adjustment.

# The information you provide will be kept in the student’s file in the Disability Services

**office** on the Cranford campus, where it will be held securely and confidentially. This form may be released to the student at his/her request.

If you have questions regarding this form, please call Disability Services at 908-709-7164. Thank you for your assistance.

# STUDENT INFORMATION

**(Please Print Legibly or Type)**

**First Name Middle Last Date of Birth Student ID#**

**Status (check one) current student transfer student former student**

**Local phone** ( ) - - **Cell phone** ( ) - -

# Address

**Union County College email address: Other email address:**

**Important: After documentation is reviewed, Disability Services will send an email notification to the student’s Union County College email acknowledging receipt of documentation and the student’s eligibility status.**

**DIAGNOSTIC INFORMATION**

**(Please print legibly or type)**

1. Date of Diagnosis:
2. Primary Diagnosis:

Secondary Diagnosis:

1. What is the severity of the disorder? **Mild Moderate Severe**
2. Please state the medication or treatment the student is currently prescribed:
3. Major Life Activities Assessment: *Please check each of the following major life activities that are impacted by the disability. Indicate severity of limitations.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Life Activity** | **Negligible** | **Moderate** | **Substantial** | **Not Sure** |
| Concentrating |  |  |  |  |
| Memory |  |  |  |  |
| Eating |  |  |  |  |
| Social Interactions |  |  |  |  |
| Self-Care |  |  |  |  |
| Regular Class Attendance |  |  |  |  |
| Speaking |  |  |  |  |
| Learning |  |  |  |  |
| Reading |  |  |  |  |
| Thinking |  |  |  |  |
| Communicating |  |  |  |  |
| Keeping appointments |  |  |  |  |
| Stress Management |  |  |  |  |
| Managing internal distractions |  |  |  |  |
| Managing external distractions |  |  |  |  |
| Sleeping |  |  |  |  |
| Organization |  |  |  |  |

1. In addition to the major life activities that are indicated above, please describe any activities that may be impacted by the disability or symptoms that may need to be addressed in the college environment:
2. Please state specific recommendations regarding academic accommodations for this student:
3. Please add any additional comments that you feel appropriate:

# HEALTHCARE PROVIDER INFORMATION

**(Please sign and date below and completely fill in all other fields using PRINT or TYPE)**

**Provider Signature Date Provider Name (print)**

**Title**

**License or Certification # Address**

**Phone Number** ( ) - -

**Fax Number** ( ) - -