OAKLAND COMMUNITY COLLEGE®

Disability Verification Form

ACCESS 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 the Title II of the American 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.

This form will assist the treating or diagnosing healthcare professional (i.e. psychologist, counselor, therapist, medical doctor) in obtaining the information needed by ACCESS to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment must be qualified to do so. These individuals should be licensed or certified to diagnose the medical or psychological condition being documented.

B. All parts of the form must be completed as thoroughly as possible. We recommend that this form should be completed by typing the information into the editable PDF version. Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process.

C. The healthcare provider should attach any reports that provide additional related information, such as psychoeducational assessments or other tests that may assist ACCESS in understanding functional limitations for an academic environment.

D. We do not accept documentation from family members related by blood or marriage. Individuals 17 and older require documentation normed for an adult. Those coming from high school require current documentation.

E. The information provided will be retained in the student's file in an ACCESS office. It will be held securely and confidentiality and may be released only at the request of the student.

(Over)

STUDENT INFORMATION

First Name _____ Middle _____ Last _____

Date of Birth _____ OCC Student ID _____

Phone Number (include area code) Home _____ Cell _____

Address _____

City _____ State _____ Zip Code _____

DIAGNOSTIC INFORMATION

Date of Diagnosis _____

Primary Diagnosis (with DMS code if applicable) _____

Secondary Diagnosis (with DMS code if applicable) _____

What is the severity of the disorder? ☐ Mild ☐ Moderate ☐ Severe

Please state the medication or treatment(s) that is(are) currently prescribed for the student:

MAJOR LIFE ACTIVITIES: FUNCTIONAL LIMITATIONS

Please list the major life activities that are impacted by the disability (i.e. walking, seeing hearing, breathing, communication). Indicate the anticipated functional limitations for an academic environment.

1. Life activity _____

2. Functional limitation _____

Other comments:

HEALTHCARE PROVIDER INFORMATION

Provider Signature _____ Date _____

Provider Name (print or type) _____

Title _____

Address _____

City _____ State _____ Zip Code _____

Phone Number (include area code) _____