OFFICE OF DISABILITY SERVICES
disabilities@mc3.edu

Physical, Chronic Health, or Sensory Disability Verification Form

(Includes but is not limited to: Mobility Impairments, Multiple Sclerosis, Cerebral Palsy, Chemical Sensitivities, Spinal Cord injuries, Cancer, AIDS, Muscular Dystrophy, Spina Bifida)

TO BE COMPLETED BY PHYSICIAN, NEUROLOGIST OR OTHER QUALIFIED MEDICAL SPECIALIST *

(*as specified in the College Guidelines)

The American with Disabilities Act (ADA; 1990; as amended, 2008) and Section 504 of the Rehabilitation Act of 1973 ensure the accessibility and availability of higher education for all qualified persons. A physical disability (which may include systemic illness) is defined by these laws as "… impairment which substantially limits one or more major life activities. . ." **These are ongoing conditions or a duration of six months or more, rather than temporary or situational difficulties.**

The Office of Disability Services assists students with physical disabilities/systemic illnesses by:

a) Establishing eligibility for services for students with physical disabilities and systemic illnesses, and
b) Arranging and overseeing the provision of reasonable accommodations for these students.

STUDENT, PLEASE COMPLETE THE SECTION BELOW:

Student's name _____ **Student's date of birth**_____

I _____ **give permission for the release of information to**
Signature of student

the Office of Disability Services at for the purpose of determining academic accommodations

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Information below to be completed by the treating professional.
For visual impairment and hearing loss, please append measures of visual function or audiogram.

1. Diagnosis(es): _____

_____

2. A summary of assessment procedures and evaluation instruments used to make the diagnosis: (*For visual and auditory disabilities, please attach assessment measu*res.) _____

_____

3. Expected duration:_____

4. How long have you been treating the student for this condition?: _____

5. Most recent contact with student:_____

6. Severity of Student's Condition(s): Mild, Moderate, Severe (for multiple conditions, please specify for each condition.) _____

7. Check all relevant major life activities that are substantially limited. _____Walking _____Hearing _____Seeing _____Working _____Sleeping _____Caring for self _____Interacting with others _____Learning (including memory/concentration) _____Performing manual tasks _____Other(s) if other, please explain: _____

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