Disability Support Services Center
2901 Liberty Heights Avenue, MNB 260 410-462-8563 (ph) 410-462-8584 (fax)

Disability Verification Form

____ may be eligible for special accommodations at Baltimore City Community College. Please review the Common Disabilities and Individuals Qualified to Render Diagnosis listed below prior to completing the attached Disability Verification Form. The diagnostician must be impartial and not a family member of the student.

Common Disabilities and Individuals Qualified to Render Diagnosis:

Attention Deficit Hyperactivity Disorder (ADHD or ADD) ADHD is considered a medical or clinical diagnosis. Individuals qualified to render a diagnosis for this disorder are practitioners who have been trained in the assessment of ADHD and are experienced in assessing the needs of adult learners. Recommended practitioners may include: developmental pediatricians, neurologists, psychiatrists, licensed clinical or educational psychologist, family physicians or a combination of such professionals.

Blind/Low Vision Ophthalmologists are the primary professionals involved in diagnosis and medical treatment of individuals who are blind or who experience low vision. Optometrists provide information regarding the measurement of visual acuity as well as tracking and fusion difficulties.

Head Injury/Traumatic Brain Injury Head injury or traumatic brain injury is considered a medical or clinical diagnosis. Individuals qualified to render a diagnosis for these disorders are practitioners who have been trained in the assessment of head injury or traumatic brain injury. Recommended practitioners include: physicians, neurologists, rehabilitation and school psychologists; neuropsychologists and psychiatrists.

Deaf/Hard of Hearing (HOH) Physicians, including otorhinolaryngologic and otologists, are qualified to provide diagnosis and treatment of hearing disorders. Audiologists may also provide current audiograms.

Medical/Physical/Systematic Disorders Includes but is not limited to: multiple sclerosis, cerebral palsy, chemical sensitivities, spinal cord injuries, cancer, AIDS, muscular dystrophy, Crone’s disease and spina bifida. Any physical disability or systemic illness is considered to be in the medical domain and requires the expertise of a physician, including a neurologist, or other medical specialist with experience and expertise in the area for which accommodations are being requested.

Psychiatric/Psychological Disorders Includes, but is not limited to, depressive disorders, post-traumatic stress disorder, bipolar disorders and dissociative disorders. A diagnosis by a licensed mental health professional including licensed clinical social workers, licensed professional counselor, psychologists, psychiatrists and neurologists is required and must include the licensee number.

Specific Learning Disabilities Professionals conducting assessment and rendering diagnoses of specific learning disabilities must be qualified. A qualified professional needs to hold a degree in a field related to diagnosis of SLD and have at least one year of diagnostic experience with adults and late adolescents. Recommended practitioners include: certified and/or licensed psychologists, learning disabilities specialists, educational therapists, and diagnosticians in public school or colleges and rehabilitation services and private practitioners with the above qualifications are typically considered qualified.

Disability Verification Form

SECTION I – TO BE COMPLETED BY STUDENT

Name: ____

Last 4 SSN: _______________________ DOB: __________________________

Address: ____

City: __________________________ State: ___________ Zip: _______________

Home Phone: _______________________ Cell Phone: _____________________

Email Address____

Physician: ____

Physician's Address:

____

I authorize the release of the information requested on this Disability Verification Form to the Disability Support Services Center at Baltimore City Community College. I understand that this information will remain confidential and will be used only in providing appropriate support necessary for the completion of Baltimore City Community College. This release of information does not permit the disclosure of these records to any other persons or entities without my written consent. I understand that at any time, through written notice, I can amend, change, or cancel this agreement with Disability Support Services Center. The revocation of this agreement will have no effect on disclosures previously made. This authorization expires one year from the date, which appears below.

Note: Should the student's condition change (for better or worse), the student must provide updated documentation so his/her accommodations can be adjusted accordingly.

____ ____________________

Signature Date

Consent For Release of Confidential Information

I, ____ the undersigned, consent to and request all appropriate persons and/or agencies or institutions to release information regarding myself to Baltimore City Community College for use in educational/vocational planning. All information will be kept confidential and maintained as part of my records with the Disability Support Services Center. I authorize the release of information to include one or more of the following records:

- ○ **Medical Reports**
- ○ **Learning Disability Assessment Reports**
- ○ **Psychiatric Evaluation Results**
- ○ **Vocational Rehabilitation Plan**
- ○ **Audiology and Speech/Language Pathology Reports**
- ○ **Other__________________________**

I further give permission for the Disability Support Services Center to discuss my educational situation with other professionals who have a legitimate educational need to know. I understand that at any time, through written notice, I can amend, change, or cancel this agreement with Disability Support Services Center.

Student Signature: ____

Student ID #: ____

Date: ____

I have reviewed this agreement with the student and witnessed the student's signature above.

Disability Support Services Center Staff: ____

SECTION II – To be completed by physician or other certifying professional.

Please provide the following information in full and attach any tests results and/or evaluations:

Specific Diagnosis:

Medical/Physical/Systematic:	
Blind/Low Vision:	
Deaf/Hard of Hearing:	
Head Injury/Traumatic Brain Injury:	
Psychological/Psychosomatic (DSM 5):	
Attention Deficit Disorder (ADHD or ADD):	
Specific Learning Disability:	

Severity: _____ Moderate _____ Severe _____ Residual/Remission

Initial Date of Treatment: ________________ **Date of Last Visit:** ________________

Duration of the Disability:

_____ Permanent _____ Temporary Expected date of recovery ________________

If patient has been prescribed medication, please complete the following:

Medication	Quantity/Frequency	Side Effects

Current compliance with treatment plan: ________ ________ ________

Poor Good Excellent

Current prognosis for functioning effectively in college: ________ ________ ________

Poor Good Excellent

SAFETY

In your opinion, does this individual represent a potential danger to self or others?

_____ Yes _____ No _____ Not Sure

SECTION III – To be completed by physician or other certifying professional.

In your professional judgment, will the disability have an impact on the student's ability to do college level work?

______ No

Yes, totally incapacitated and should:

______ Withdraw from college at this time

______ Not register for courses this semester

______ Not recommended for college at this time

Please check which of the major life activities listed are affected because of the disability.

______ Walking
______ Speaking
______ Seeing
______ Hearing
______ Concentrating
______ Learning
______ Memory
______ Breathing
______ Managing Internal Distractions
______ Managing External Distractions
______ Performing Manual Tasks
______ None
______ Other:

____

Briefly describe the current functional limitations on major life activities as a result of the disability and explain how the disability will affect the student in the academic environment.

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____

SECTION IV – To be completed by physician or other certifying professional.

Are Accommodations Recommended? _____Yes _____No

All recommendations for accommodations should be directly related to the functional limitations. Clearly state how the accommodation mitigates the impact of the student's disability on specific tasks and activities.

Accommodation	Rationale

Please Print

Name: ____

Title: ____

Business Address: ____

____

Phone: ______________________________ Fax: ____________________________

Professional Credentials: ____

License/Certification Number ____

I have read the list of <u>Common Disabilities and Individuals Qualified to Render Diagnosis</u> provided and verify that the above information is complete and accurate to the best of my knowledge.

____ ______________________

Signature Date

Thank you for your help in providing this information so that we may begin providing services and/or accommodations. Eligibility for services and/or accommodations is heavily based on the documentation provided. Therefore, incomplete or missing information can prevent or delay the provision of accommodations and/or services.