



Dear Health Care Provider:

One of your patients is requesting accommodations at Davidson County Community College due to a disability. Disability Services will review the medical information you provide and make a recommendation for appropriate services and accommodations in order for the student to equally participate in all programs and services at the college ensuring compliance with Section 504 of the Rehabilitation Act of 1973 and The Americans with Disabilities Act Amendments Act of 2008 (ADAAA).

Often times, as a part of our process for a student to be considered eligible to receive an accommodation, documentation is submitted to the Office of Disability Services to show how a disability substantially limits one or more of the student's major life activities. Information within this verification form should be completed by a qualified health care professional. Current and comprehensive information is required in order to determine appropriate services and accommodations. Accommodations that fundamentally alter the nature of the program, lower or waive essential academic requirements or result in undue financial or administrative burdens will not be granted.

1. All parts of the Disability Verification Form must be completed. Inadequate information, incomplete answers and/or illegible handwriting may delay the eligibility review process by necessitating follow up contact for clarification. The health care provider can attach any reports which provide additional related information.
2. Please complete a Disability Verification Form for each diagnosis to ensure consideration of all aspects of a student's needs.
3. After completing and signing the Disability Verification Form, please fax or mail to Disability Services at the address listed on the form or return the forms to your patient for submitting. The information you provide will be kept confidential in accordance to the Family Educational Rights and Privacy Act (FERPA) and may be released to the student upon his/her request.
4. Documentation for the request of services may take time to process and should be provided as soon as possible.

If you have questions regarding this form or opportunities for your patient, please contact Disability Services at the information listed below.

Thank you for your assistance!

A handwritten signature in black ink, appearing to read 'Whitney Lewis', is written over a light blue circular stamp.

Whitney Lewis
Disability Services Counselor - Office of Disability Services
Davidson County Community College
Mailing Address: P.O. Box 1287, Lexington, NC 27293
Office: Brooks Student Center 207
Phone: 336-249-8186 ext. 6342
Fax: (336) 249-0379

Davidson County Community College Disability Verification Form
Please return form to: Davidson County Community College – Office of Disability Services
P.O Box 1287, Lexington, NC 27293 – Phone (336) 279-8186 – Fax (336) 249-0379

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Student Last Name _____ First Name _____ MI _____ Date of Birth _____

Date Requested _____ Phone # _____ DCCC Student ID# _____

THIS SECTION MUST BE COMPLETED BY A LICENSED PROFESSIONAL

This student may be eligible for services and accommodations at Davidson County Community College. In order to provide appropriate services we must have verification of a disability diagnosis and limitations. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Davidson County Community College. Please complete a Verification Form for each diagnosed disability to ensure consideration of all aspects of the student's needs.

1. Diagnosis: _____
(If applicable, include DSM IV Code)

2. Date of Onset: _____ End Date or Re-Evaluation Date: _____

3. Severity: Mild Moderate Severe Other _____

4. Duration of Condition: Permanent/Chronic Temporary - give estimated duration _____ Residual/Remission

5. Condition is: Stable Prone to exacerbations Observable Non-Observable

6. Prescribed Medication (s), Dosage and Side Effects:

7. Functional limitations of conditions and/or medication (i.e. the ways in which the diagnosis affects the student):

Attention and/or Concentration Planning and/or Organization Memory Stamina
 Mobility Speaking Sitting Hearing –attach audiogram if possible
 Writing Processing Oral Materials Vision: _____ Reading
 Processing Visual Materials Acuity: R _____ L _____ Sleeping
 Other _____

8. Please list other limitations or information helpful in determining necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations in an educational setting:

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Signature of Verifying _____ Licensed Professional Title/License # _____ Date _____

Name (printed) _____

Address _____ Phone _____
