MONTGOMERY
COUNTY COMMUNITY COLLEGE

OFFICE OF DISABILITY SERVICES
disabilities@mc3.edu

Physical, Chronic Health, or Sensory Disability Documentation Guidelines

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

Submission of documentation is not the same as the request for services. The request for reasonable accommodations must be initiated by the student once they are confirmed at the College. The student must schedule and participate in an Intake appointment with the Office of Disability Services so that support services and reasonable accommodations can be discussed in an interactive process. Documentation will be reviewed by the Office of Disability Services prior to the appointment. The Office of Disability Services is responsible for and will have the final the determination of reasonable accommodations.

- Documentation should be submitted by a physician, neurologist, psychiatrist, or other medical specialist qualified to diagnose and treat the student's condition.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.
- Documentation should include the names, titles, professional credentials, license number, addresses, and phone numbers of the evaluators as well as the date of the report.

Please provide a clear statement of the disability, including the DSM-V diagnosis and a summary of present symptoms.

1. Documentation for eligibility should be recent and address the current functional impact of the condition on the student's performance on his or her academic performance.
2. A summary of assessment procedures and evaluation instruments used to make the diagnosis, including evaluation results and standardized scores if applicable.
3. A description of present symptoms and any impairment of daily activities of living.
4. Information about the student's needs may include the impact of medications upon the student's function in the post-secondary environment.
5. Suggestions for reasonable accommodations that might be appropriate at the *postsecondary level* are encouraged. **Each recommendation should be supported by the diagnosis and clearly linked to the current impact of a functional limitation of the student's disability.**

Disability documentation is confidential and should be submitted only to the Office of Disability Services.

The Office of Disability Services maintains disability files and diagnostic testing information for seven years after the student either graduates, transfers, or leaves the College. After that time, the confidential files are destroyed. If a student does not attend the College but has submitted documentation, the files will be destroyed after two years. Consequently, the student should maintain their own copy of the diagnostic information.

MONTGOMERY
COUNTY COMMUNITY COLLEGE

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

---

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: _____

8. Please describe how each limitation will affect the individual's ability to function in the post-secondary academic environment._____

_____

_____

9. Have you any recommendations to make regarding effective academic accommodation to equalize this student's educational opportunities at the post-secondary level? **Please state the rationale for each suggested accommodation relating it to a specific functional limitation.** _____

_____

_____

_____

10. If the student is currently on medication for this condition, please describe specific impact (if any) of the medication on the student's ability to meet the demands of the postsecondary environment:

_____

11. Other Comments: _____

_____

Please note that the Office of Disability Services will make all final determinations of reasonable accommodations.

Signature of practitioner: _____Date: _____

Print name and title: _____

Specialty/qualification to treat student's condition: _____

Type of License/ Certification: _____State of License and No.: _____

Address: _____

Telephone: _____ **Fax:** _____ **Email**:_____

This form will be uploaded by the student to be sent to our office VIA a Secure File Transfer link. If you wish to send a copy to the Office of Disability Services, please use our Secure File Transfer link (https://sft.mc3.edu/filedrop/disabilities) or fax 215-619-7174. If faxed, please include a cover sheet with student's name and birthdate.

Office of Disability Services
College Hall
340 DeKalb Pike
Blue Bell, PA 19422
FAX : (215) 619-7174
disabilities@mc3.edu