OCEAN COUNTY COLLEGE

STUDENTS: DO NOT FILL OUT THIS FORM

FORM A

VERIFICATION OF PHYSICAL DISABILITIES & HEALTH DISORDERS

The following information will assist the Disability Services staff in collaborating with the student to determine appropriate accommodations. Documentation serves as a foundation that legitimizes a student's request for accommodations.

Please complete this form in its entirety. If not complete, we reserve the right to reject the documentation which will result in a delay of accommodation approval.

This documentation requires the expertise of a physician or other medical professional with experience and expertise in the area for which accommodations are being requested.
This professional must be an impartial individual who is not a family member of the student.
The name and contact information for the professional must be clearly stated.

Following Family Education Right and Privacy Act (FERPA), information submitted will become an educational record and can be released to the student named below upon his/her request.

Student Name ______________________________ Date of Birth ______________

Please provide a clear statement of the medical diagnosis of the disability or illness:

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Describe present symptoms that meet the criteria for diagnosis and attach supporting test results.**

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**Attach current audiogram for deaf/hearing impairment or visual acuity measurements for blind/low vision. For head/brain injury, attach summary of cognitive and achievement measures utilized and results including standardized test scores used for diagnosis.

Describe the current impact the medical diagnosis has on the student's educational abilities and the limitations of the disability on learning or other major life activities.

List current medications and dosages and include the impact of medication on memory and learning.

Please list specific and reasonable academic accommodations for the student's needs in a campus or educational environment (classroom, lecture or lab).

Medical Professional's Contact Information. Please attach cognitive and achievement diagnostic reports including standardized testing scores.

PROFESSIONAL'S NAME, TITLE, AND CREDENTIALS

PROFESSIONAL'S SIGNATURE

DATE

PROFESSIONAL'S ADDRESS

STATE

ZIP CODE

PROFESSIONAL'S TELEPHONE

PROFESSIONAL'S EMAIL

NOTE: Further assessment by an appropriate professional may be required if co-existing learning disabilities or other disabling conditions are indicated.