

VERIFICATION OF MEDICAL DISABILITY

The Disability Support Service (DSS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided regarding the disability diagnosis must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990. The ADA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. In addition, in order for a student to be considered eligible to receive academic accommodations, the documentation must show functional limitations that impact the individual in the academic setting.

DSS requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

A. The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so. These persons are generally trained, certified or licensed members of an appropriate medical specialty.

B. All parts of the form must be completed as thoroughly as possible. Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification. (See C. for exception)

C. The healthcare provider should attach any reports which provide additional related information (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Otherwise, this form must be completed in order for students to receive services through the Disability Support Service (DSS) at Montgomery College.

Please do not provide case notes or rating scales without a narrative that explains the results.

D. The Healthcare Provider after completing this form, or attaching appropriate documentation, as per C above, must sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to the address provided in our letterhead. The information you provide will not become part of the student's educational records, but it will be kept in the student's file at DSS, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please contact DSS. Thank you for your assistance.

* Documentation must be current (appropriate given the nature/stability of the diagnosis)

* This form is not acceptable documentation for Attention Deficit Disorders (ADD/ADHD), Learning Disabilities (LD), or Psychological disabilities.

MED

STUDENT'S INFORMATION
(Please Print Legibly)

Student's Name:		<input type="checkbox"/> Mr.	<input type="checkbox"/> Ms.
Student's Date of Birth: ____ / ____ / ____	Student's Phone Number:		

MEDICAL INFORMATION
(Please Print Legibly)

Specific Diagnosis:	Initial Date of Treatment: ____ / ____ / ____
Date of Last Visit: ____ / ____ / ____	Date of Next Visit: ____ / ____ / ____
<u>The Expected Duration of the Condition/Disability</u>	
<input type="checkbox"/> Permanent <input type="checkbox"/> Temporary - Expected Date of Recovery: ____ / ____ / ____	

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.

1. Please check which of the major life activities listed below are affected because of the medical diagnosis. Please indicate the level of limitation.

Life Activity	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Critical Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Motor Skills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attending Class Regularly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization/Executive Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Following Directions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Putting Thoughts Into Words	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carrying Objects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Student's Name

2. Please indicate recommended academic accommodations based on medical necessity (e.g. note takers, extended time for tests, large print etc.)

3. Does the student take any medications? If so, please list the quantity and frequency?

1. _____ 2. _____
3. _____ 4. _____

4. What potential side effects are associated with the medication(s) listed above?

HEALTH PROVIDER INFORMATION

**Please sign & date below and completely fill in all other fields using PRINT or TYPE.
(Please use office stamp.)**

Provider Signature:	Provider Name (PRINT):	Date:
Title:		License or Certification#:
Address:		
Phone Number:	Fax Number:	

Please send this information to the campus that the student attends.

Please submit to only one campus.

<input type="checkbox"/> Rockville Campus: Montgomery College Disability Support Services 51 Mannakee Street, CB122 Rockville, MD 20850 Phone: 240-567-5058 Fax: 240-567-5097	<input type="checkbox"/> Germantown Campus: Montgomery College Disability Support Services 20200 Observation Drive, SA175 Germantown, MD 20876 Phone: 240-567-7770 Fax: 240-567-1985	<input type="checkbox"/> Takoma Park/Silver Spring Campus: Montgomery College Disability Support Services 7600 Takoma Avenue, ST122 Takoma Park, MD 20912 Phone: 240-567-1480 Fax: 240-567-3922
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