HARFORD COMMUNITY COLLEGE
CERTIFICATION OF ONE OF THE FOLLOWING CONDITIONS:
MOBILITY, PHYSICAL/HEALTH or NEUROLOGICAL

The student named below has applied for services from Harford Community College's Disability and Student Intervention Services. In order to be able to determine eligibility and what, if any accommodations are warranted, documentation or additional documentation is needed.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability limits one or more major life activities (e.g. learning). *A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations.* The documentation must also support the request for accommodations and explain how the disability impacts learning.

Please complete this form and return by mail, email or fax to:

Harford Community College
Disability and Student Intervention Services
401 Thomas Run Road
Bel Air, Maryland 21015
Attn: _____
Fax: 443.412.2200
Email: disabilitysupport@harford.edu

Student's Name: _____ Date: _____

Clinician's Name: _____ Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Signature: _____

All items must be completed in full. Professionals conducting the assessment and rendering a diagnosis must be qualified to do so (e.g. a licensed physician). The provider signing this form must be the same person answering the questions on the form below.

Please note: it is NOT appropriate for professionals to evaluate members of their family or others with whom they have personal or business relationships.

Name of Student: _____ Date of Birth: _____

I, _____, authorize a release of information, allowing the Disability and Student Intervention Services Office at Harford Community College to contact the physician completing this form to obtain additional information or clarification in order to determine reasonable accommodations.

_____ _____
Signature Date

DISABILITY RELATED INFORMATION

1) Date of Diagnosis: _____

   Primary Diagnosis and Diagnostic Code (ICD) _____

2) How long has the student had this condition? _____
   a. Please check the severity of the condition. ❑ Mild ❑ Moderate ❑ Severe
   b. Please explain the severity checked above. _____

      _____

      _____

3) Please check to indicate the expected duration. ❑ Chronic ❑ Episodic ❑ Short – term
   a. Please explain the duration checked above including the progression and stability of the condition.

      _____

      _____

      _____

4) Please provide information regarding the student's current symptoms.

   _____

   _____

   _____

5) Appointments with student:
   a. The date you begin treating this patient: _____
   b. Date of last visit: _____
   c. How often does this student receive treatment: ❑ Weekly ❑ Monthly ❑ Annually ❑ As Needed

6) Has there been any changes in the student's condition in the past 12 month? ❑ Yes ❑ No

   If yes, please explain_____

7) Do you anticipate any changes in the individual's condition/medication in the next 12 months? ❑ Yes ❑ No

   If yes, please explain _____

8) Dates and results of diagnostic assessment(s) _____

   _____

   _____

   _____

   _____

9) Please check which areas listed below the individual is functionally limited in because of the medical condition/ and or the medication. Please indicate the level of limitation

0 – No Impact 1 – Mild Impact 2 – Moderate Impact 3 – Substantial Impact 4 – Unable to Determine

0	1	2	3	4	Major Life Activities	Please describe if moderate or substantial impact
					Walking (e.g, how far/long can student walk, use mobility devices such as wheelchair, etc.)	
					Climbing Stairs	
					Standing	
					Sitting	
					Using a computer	
					Writing	
					Eating	
					Using the bathroom	
					Hearing	
					Performing manual tasks (e.g. reaching, carrying, lifting, manipulating materials & lab equipment)	
					Thinking	
					Self-care (e.g. use the restroom, shower, prepare meals, getting dressed, etc.)	
					Communicating with others	
					Working	
					Speaking	
					Vision (attach most recent eye exam)	
					Sleeping	
					Memory	
					Concentration	
					Listening	
					Organization	

HISTORY

Please describe any relevant medical history, psychological history, and hospitalizations:

_____

_____

_____

_____

CURRENT MEDICATION:

Is the student currently taking medication(s) for condition? ❑ Yes ❑ No

If yes, please list current medication, any side effects and those impacting academic performance.

Medication & Dosage	Side Effects	Academic Impact

Do limitations/symptoms persist even with medications? If yes, please explain:

_____

_____

_____

ACCOMMODATIONS

Please indicate your recommendations and justifications regarding classroom and/or testing accommodations in the college environment. Justifications should specify how the accommodations and strategies directly relate to the symptoms and/or functional limitations (e.g., extended time because of focusing difficulties).

Please note: At the college level, the purpose of an accommodation is to correct or circumvent a functional impairment rather than to ensure a student's success. In reviewing the accommodations requested by the student or recommended by an evaluator, the DSIS Office may find that the accommodation is not appropriate given the requirements of a course or program. DSIS may propose an alternative accommodation that would be appropriate for the student, but which neither the student nor evaluator has requested.

Recommended Accommodations	Justification