VERIFICATION OF DISABILITY FORM FOR MEDICAL PROVIDERS

Return to the attention of:

4525 Education Park Drive
Schnecksville, PA 18078

Fax: 610-799-1068

- ☐ Allison White
- ☐ Michelle Mitchell - SEED
- ☐ Kristen Lenhart
- ☐ Amanda Walters

Purpose: The student named below has indicated that s/he has a disability and will require reasonable accommodations to participate in a program or activity at Lehigh Carbon Community College (LCCC). The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services.

Please take the time to complete this form in its entirety. Contact Disability Support Services at 610-799-1156 with any questions. All information provided will be kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).

The student's signature below is permission for you to release information to DSS at LCCC. Thank you for your assistance.

Please note: For hearing disabilities, please attach the most recent audiogram. For visual disabilities, please attach acuity information. For neurological disabilities, any completed objective testing with results.

Student Name: (To be completed by student) _____

Student Signature: (To be completed by student) _____

Date of Birth: (To be completed by student) _____

The following information to be completed by provider:

1. Date of initial contact with student: _____
2. Date of last contact with student: _____
3. Does the student have a clinical history of the condition's symptoms? Yes ☐ No ☐
   a. Approximately at what age did the student start exhibiting symptoms? _____
   b. At approximately what age was the student diagnosed with the condition? _____
4. Medical Diagnosis(es); DSM-5/ID Codes:

_____

_____

_____

5. What are the student's current functional limitations?
Functional Limitation/Major Life Activities:

- ☐ Reading
- ☐ Writing
- ☐ Math
- ☐ Hearing
- ☐ Seeing
- ☐ Upper Body Motor Function
- ☐ Lower Body Motor Function
- ☐ Interpersonal Skills
- ☐ Decision-Making
- ☐ Stamina
- ☐ Motivation/Initiative
- ☐ Concentration
- ☐ Memory
- ☐ Following Instruction
- ☐ Judgment
- ☐ Psychosomatic (i.e. headache, back pain, muscle cramps, nausea, slowness and speech/thought/movement)
- ☐ Organization
- ☐ Socialization/Teamwork
- ☐ Attendance
- ☐ Low Frustration Tolerance
- ☐ Pain
- ☐ Problems with Motor Coordination
- ☐ Meeting Deadlines
- ☐ Difficulties with Receptive Speech
- ☐ Difficulties with Expressive Speech
- ☐ Sensory
- ☐ Performing Manual Tasks
- ☐ Caring for Oneself
- ☐ Working
- ☐ Eating
- ☐ Sleeping
- ☐ Walking
- ☐ Standing
- ☐ Sitting
- ☐ Reaching
- ☐ Lifting
- ☐ Bending
- ☐ Speaking
- ☐ Breathing
- ☐ Learning
- ☐ Concentrating
- ☐ Fluency
- ☐ Thinking
- ☐ Communicating
- ☐ Interacting with Others

☐ Other Functional Limitation/Major Life Activity: _____

6. What is the severity of the student's functional limitations noted above, both with and without the use of mitigating measures (interventions), such as medication and treatment:

<u>Without Mitigation (Intervention)</u>:

- ☐ Mild
- ☐ Moderate
- ☐ Substantial
- ☐ Severe

<u>With Mitigation (Intervention)</u>:

- ☐ Mild
- ☐ Moderate
- ☐ Substantial
- ☐ Severe

7. What exacerbates the condition this student has? (*again, be as specific and detailed as possible*)

- ☐ Fatigue
- ☐ Stress
- ☐ Being Overwhelmed
- ☐ Social Interactions
- ☐ Weather
- ☐ Noise
- ☐ Crowds

☐ Other Items That Exacerbate Condition _____

8. Please list any medications related to the condition(s) that the student is currently taking, including dosage and frequency, if pertinent. Please include both the positive as well as any negative effects of the medication:

Medication/Dosage/Frequency	Side Effects

9. Please describe the evidence that the student's condition will interfere or reduce the quality of functioning in the areas listed below. Write N/A if the period is not impacted by the condition.

School Functioning: _____

Social Functioning: _____

Work Functioning: _____

10. Was there objective evaluations completed to obtain information about the student's symptoms and functioning? Yes ☐ No ☐

    Please describe the specific evaluations completed.

    If no, how did you reach your conclusion about the diagnosis and treatment?

11. Please list any recommended accommodations to help mitigate specific symptoms related to the student's condition.

Recommended Accommodation	Specific Symptom Mitigated

Physician's Contact Information

Name of Medical Professional: _____

Credentials: _____

License #: _____

State of Licensor: _____

Address: _____

Telephone: _____

E-mail Address: _____

Signature: _____

Date: _____

Signature of Provider: _____

PERM24B-c (AC)
9/20/22