Rowan-Cabarrus COMMUNITY COLLEGE

Office of Accessibility
Disability Documentation Form

Student Name: _____ **Student ID:** _____

IMPORTANT: The Americans with Disabilities Act (ADA) and the ADA Amendments Act of 2008 (ADAAA) define a disability as a physical or mental impairment that substantially limits one or more major life activities. Thorough completion of this form is necessary for the Office of Accessibility (OA) to determine eligibility for accommodations. Insufficient information may result in delays or ineligibility. **Complete one documentation form for each diagnosis or condition.** Please note the following information:

- Any record provided to OA becomes part of the student's "education record" pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protections and access provisions of FERPA, the student has the right to inspect his or her own education records if requested.
- A learning disability diagnosis must be accompanied by a current, appropriate psycho-educational evaluation, including the diagnostic test scores.
- Visual or hearing loss documentation must include an acuity and/or audiology report that addresses the current impact of the disability, as well as information about the specific assistive technology used by the student.

To Be Completed by Diagnostician or Treating Professional

Date of birth: _____

Diagnosis: _____ DSM-V or ICD code: _____

Date of diagnosis: _____ Date of most recent office visit: _____

Does this disorder substantially limit the student? ☐ **Yes** ☐ **No**

Attach any supporting documentation: e.g., psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc. ☐ Supporting documentation attached

Describe the student's condition, symptoms, and the impact on life activities, including academics:

_____

_____

_____

_____

Treatments, medications, assistive devices/services currently prescribed or in use:

_____

_____

_____

Will medication adversely impact this student, if so how?

_____

_____

_____

Expected duration of the impact of the disability:

- ☐ Temporary - Indicate anticipated recovery date: _____
- ☐ Permanent
- ☐ Chronic
- ☐ Episodic/Recurring

Expected progression or stability of the impact of the disability:

_____

Recommended accommodations related to disability, including those used in the past:

_____

_____

_____

_____

Name of Diagnostician/Professional: _____

Signature:_____Date: _____

License #: _____

Organization:_____Phone #: _____

Please attach a copy of your business card and submit the accompanying report to the counselor as requested by student/patient:

Office of Accessibility
Rowan-Cabarrus Community College

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