

DOCUMENTATION OF DISABILITY

NAME: _____
Last First MI

ADDRESS: _____
Street Apt. #
_____, _____
City State Zip Code

Student ID # _____

PHONE: () _____ - _____ (__wk., __hm., __cell, __ msg.)

I hereby apply for special services at Cochise College. I understand that the following information documents my request for reasonable accommodation(s) while a student at Cochise College. I agree to provide Cochise College with all necessary documentation from a certified professional as evidence of my disability. I further understand that I may be required to provide additional evidence of the need for a particular accommodation.

AUTHORIZATION TO RELEASE INFORMATION TO COCHISE COLLEGE

Permission to release my medical and/or psychological records pertinent to my request for reasonable accommodation(s) to verify my request for special services at Cochise College is hereby granted.

Signature of Requestor

Signature of Parent or Guardian (under 18)

THE REMAINDER OF THIS FORM IS TO BE COMPLETED BY THE CERTIFYING PROFESSIONAL

DISABLING CONDITION:

___ Physical disorder (diagnosis) _____

___ Emotional disorder (diagnosis) _____

___ Learning disability (diagnosis) _____

___ Other (please describe condition) _____

NOTE: All information provided above is confidential and intended only for those personnel with a need to know.

BACKGROUND OF CERTIFYING PROFESSIONAL

- 1. What license or certification do you hold?
 - Certified/Licensed Clinical/Educational Psychologist
 - Certified/Licensed Language Therapist
 - Neuropsychologist
 - University-Based Clinical Staff
 - Division of Rehabilitation Services Certification
 - Public School/Community College Psychologist/Psychometrist
 - Department of Education Diagnostician
 - Other (specify) _____

- 2. Education: degree area
 - MD Psychology
 - Ph.D. Special Education
 - M.A. Education
 - Ed.D. Speech Pathology and Audiology
 - M.Ed. Other (specify) _____

DOCUMENTATION

- 1. Diagnostic Instruments Used (since underachievement is not a disabling condition, tests of achievement can only be used to illustrate implications of a disability.)
 - Clinical Interview and History (Is there a full-scale evaluation on file?)
 - Stanford Binet Intelligence Scale R
 - Wechsler Adult Intelligence Scale R
 - Woodcock-Johnson Psycho-Educational Battery
 - Wechsler Memory Test
 - Visual Aural Digit Span
 - Bender Visual Motor Gestalt
 - Ayers Tests of Sensory-Motor Integration
 - Spondaic Word Patterns
 - Halstead-Reitan Battery
 - Positron Emission Topography Scan (PET scan)
 - Motor Dexterity
 - Other (specify) _____

NOTE: All information provided above is confidential and intended only for those personnel with a need to know.

LEARNING DISABILITY

Inherent Discrepancies:

___ Verbal exceeds non-verbal (specify significance) _____

___ Non-verbal exceeds verbal (specify significance)_____

___ Short-term memory deficits (specify) _____

___ Attention Deficit (estimated attention span) _____

___ Interest Scatter (specify) _____

PHYSICAL DISABILITY/DISABLING CONDITION

___ Mobility Impairment (describe) _____

___ Visual Impairment (describe) _____

___ Hearing Impairment/Deafness (extent of hearing loss) _____

___ Seizure Disorder

___ Other (specify)_____

EMOTIONAL DISABILITY

___ DSM IV Diagnosis Axis I: _____

 Axis II: _____

Current Global Assessment of Functioning Scale (GAF) _____

STATEMENT OF NEED

Briefly describe the precise need for accommodation(s) for this individual. _____

SPECIALIZED INTERVENTIONS

Briefly describe the specialized interventions (e.g. special instruction) that have been attempted and with what results? _____

NOTE: All information provided above is confidential and intended only for those personnel with a need to know.

RECOMMENDED ACCOMMODATION(S) (check only those required)

- | | |
|---|---|
| <input type="checkbox"/> Note Taker | <input type="checkbox"/> Magnification Device |
| <input type="checkbox"/> Extended Time for Testing | <input type="checkbox"/> Enlarged Print Text/Text |
| <input type="checkbox"/> Quiet Testing Environment | <input type="checkbox"/> Audio Books |
| <input type="checkbox"/> Interpreter for the Deaf | <input type="checkbox"/> Preferred Parking |
| <input type="checkbox"/> Spelling Aid | <input type="checkbox"/> Preferred Seating |
| <input type="checkbox"/> Tape Recorder | <input type="checkbox"/> Other (specify) _____ |
| <input type="checkbox"/> Use of Calculator | _____ |
| <input type="checkbox"/> Voice-Recognition Software | |

(Name/Title – please print)

Organization

() _____ @ _____
Telephone Email

Signature of Certifying Professional

Date

Please forward completed form to:

Office of Disability Services
Cochise College
901 N. Colombo Ave.
Sierra Vista, AZ 85635

Fax: (520) 515-5360
Office: (520) 515-5337
(520) 417-4023

NOTE: All information provided above is confidential and intended only for those personnel with a need to know.