Received On: _____

OFFICE OF DISABILITY SERVICES COVER SHEET

Contact Information

(to be completed by the student)

Name: _____ Student ID: _____

Phone: (_____) - _____ - _____ Home Phone: (_____) - _____ - _____

Email: _____

Address: _____

Nature of Disability: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (_____) - _____ - _____

Check Appropriate Box:

- ☐ Day Student
- ☐ Evening Student
- ☐ Adult Basic Education (ABE)
- ☐ Workforce Development
- ☐ Online Student

Are you currently registered for classes at STCC? _☐_ Yes _☐_ No

If no, which semester will you start taking classes? _____

How would you prefer to receive your ODS information? _☐_ Mailed _☐_ Emailed

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For Office Use Only

Sent information to student on: _____ By: _____ Mail _____ Email

Notes:_____

_____

_____

Staff Initials: _____

STCC
Springfield Technical Community College

One Armory Square
Suite 1 • PO Box 9000
Springfield, MA 01102-9000
(413) 781-7822 • www.stcc.edu

Office of Disability Services Disability Verification Record

Visual Disabilities

To determine eligibility and ensure provision of appropriate academic accommodations through the Office of Disability Services, STCC requires students to provide current, comprehensive documentation of disability. The Americans with Disabilities Act defines a disability as a physical or mental impairment that *substantially* limits one or more major life activities. Comprehensive documentation includes a diagnosis, severity and limitations to functional activities. Documentation must be completed by an appropriately credentialed practitioner (who is an impartial individual and not a family member of the student).

Consent for Release of Information (to be completed by the student)

I, _____, authorize the release of the following information to the Office of Disability Services at STCC to be used to determine my eligibility for academic accommodations.

_____

Street Address City State Zip

_____ (____)_____

Student Signature Date of Birth Student ID # Phone

Disability Verification (to be completed in full by the appropriately credentialed practitioner)

Please note the final determination of appropriate academic accommodations will be decided by the STCC Office of Disability Services in accordance with the mandates of the Americans with Disabilities Act.

Primary Diagnosis(es):_____

Does this condition substantially limit the student? Yes No

Date of original diagnosis: _____ Date of last office visit: _____

What is the student's visual acuity with best correction? _____

What is the expected duration of this condition? _____

Describe the symptoms associated with this diagnosis exhibited by the student: _____

Identify how this condition may affect the student in an academic setting:

_____

_____

List any assistive technology and/or adaptive equipment currently being used, including brand name, model number and a brief description of the equipment and suggestions for adaptive equipment in the classroom.

_____

_____

What supports do you recommend that would assist this student in an academic setting (i.e., time-and-a-half for testing, distraction-reduced testing environment, etc.)?

_____

(Functional limitation) (Recommendation)

_____

(Functional limitation) (Recommendation)

Optional:

List current medication(s) and ***identify how the medication might adversely impact the student in an academic setting:***

_____

_____

Please provide any additional information that would be helpful in providing support to the student:

_____

_____

Printed Name of Credentialed Practitioner: _____

Area of Specialty: _____

_____

Street Address City State Zip

_____(____)_____

Signature Date Phone

Please attach a copy of your business card and send any additional supporting documentation to:

Office of Disability Services
Springfield Technical Community College
One Armory Square, Suite 1,
PO Box 9000
Springfield, MA 01102-9000
Phone: (413)755-4785 Fax: (413)755-6323