SUNY Fulton-Montgomery
A State University of New York Community College

FMCC Disability Academic Accommodation Verification Form

Dear Student:

As a student at Fulton-Montgomery Community College, you have requested accommodation because of a disability. Please have your licensed physician/psychologist, psychiatrist, school psychologist, or social worker review this letter and complete the attached Disability Academic Verification Form in order to document your disability. This form outlines the specific information that we need to determine a reasonable accommodation plan for you.

Please review the following information before completing the verification form:

1. For accommodation purposes, an individual with a disability under Section 504 of the Rehabilitation Act of 1973 or the Americans with Disabilities Act of 1990 (ADA), is a person who has a physical or mental impairment that substantially limits one or more major life activities. Major life activities include, but are not limited to walking, seeing, hearing, speaking, breathing, learning, working, caring for oneself and/or other similar activities.
2. The presence of a disorder/condition by itself does not necessarily qualify an individual for accommodations under Section 504 or the ADA. It is the substantial limitation(s) on one or more major life activities due to the disorder or condition that will be the determining factor(s) in eligibility for specific accommodations. The information you provide regarding the functional limitations this individual is likely to have in a college setting—both inside and outside of the classroom—due to his/her disability will be critical in helping us determine reasonable accommodation.
3. Please make explicit connections between the individual's functional limitations and any recommended accommodations.

Please send the completed verification form to the appropriate disability official.

Katherine Norman
Coordinator of Accessibility, Counseling & Alternative Testing Services
Office L-102, The Commons, Evans Library Building
Fulton-Montgomery Community College
2805 State Hwy 67
Johnstown, NY 12095
Voice 518-736-3622 Ext. 8145
Fax 518 762-1273
Email knorman@fmcc.edu

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This form must be completed by a qualified licensed healthcare professional.

The student named below has represented that they have a disability which will require academic accommodation at FMCC. The information you provide will be used to determine the appropriateness of the requested accommodation(s).

Date:

I. STUDENT INFORMATION

Last Name	
First Name	
Student ID	
Date of Birth	
Address	
Address	
City, State, Zip	

II. CERTIFYING PROFESSIONAL INFORMATION

Name	
Credentials	
Address	
Address	
City, State, Zip	
License number and State of Licenser	

III. DIAGNOSTIC DATA

Diagnosis: Please identify the physical or mental impairment for which you are treating the student (the student's diagnosis or disability).
Level of Severity: (circle one) Mild Moderate Severe
Date of Diagnosis:
What procedures were used to assess/diagnose? Please attach diagnostic report(s).

Describe symptoms which meet the criteria for the diagnosis with approximate date of onset and history of presenting problems:
Describe this student's functional limitations in an educational setting (e.g., easily distracted; poor concentration; difficulty focusing for extended periods of time; difficulty formulating and executing plan of action; difficulty overcoming unexpected obstacles; panic or confusion in unfamiliar surroundings and situations, etc.).
How long have you been treating the student?
When was the last date of treatment you had with the student?
History of Hospitalizations:
If hospitalized, dates of hospitalization:
Does the person currently pose a threat to themselves or others? Yes/No If yes, please explain.

IV. THERAPEUTIC INTERVENTIONS

Is this student currently on medication? (circle one) YES/NO (If yes, state medication and dosage)
Therapeutic interventions and current plan of treatment.
Is the student compliant with therapeutic interventions? (circle one) YES/NO
Prognosis for treatment.

Provide a medication history related to this disability.
Does this student continue to need the services or accommodations listed in Section V when utilizing any recommended medications? (circle one) YES/NO

V. IMPLICATIONS FOR THE COLLEGE ENVIRONMENT

Implications for academic success:
Implications for social interaction:
Learning abilities specific to the post-secondary environment that are impaired by ADD/ADHD (e.g., difficulty with concentration, slow processing speed etc.:
Implications for taking exams and other classroom activities caused by ADD/ADHD or medications (please specify which):
Other Implications:

VI. SUGGESTED ACCOMMODATION PLAN

NOTE: Final determination of the appropriate accommodation will be determined by the Coordinator of Accessibility, Counseling & Alternative Testing Services based on consultation, as needed, with appropriate campus professionals in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.

Each recommended accommodation should be accompanied by an explanation of its relevance to the disability that is diagnosed.

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Which academic accommodation(s) are you requesting? (Please list and describe as needed).
Extension of time to complete exams (time and half or double the amount of extended time). (circle one) YES/NO
Rationale:
Alternative testing room in which to take exams? (circle one) YES/NO
Rationale:
Extension of a deadline to complete an assignment. (circle one) YES/NO
Rationale:
Modified class schedule (time of class, breaks). (circle one) YES/NO
Rationale:
Reduced course load. (circle one) YES/NO
Rationale:
Other:
Rationale:

All documentation of a student's disability is kept strictly confidential and is not released without written permission from the student or by order of the court. Please submit documentation and/or inquiries to the office checked below.

Healthcare Professional Name:	
Address:	
State:	
Professional License:	
License Number:	
Signature:	
Date:	