Date: _______________________
Dear: _______________________ 

As a student at Fulton Montgomery Community College, you have requested accommodations because of a disability. Please have your physician/psychologist review this letter and complete the attached Disability Verification Form in order to document your disability. This form outlines the specific information that we need to determine reasonable accommodations 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 one’s self 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 your patient’s functional limitations and any recommended accommodations.

Please mail the completed verification form to

Academic Support Counselor-Disability Services for physical and mental disabilities Robin DeVito, 2805 St. Hwy 67, Fulton-Montgomery Community College, New York 12095 or fax to 518:762-6518, If you have any questions or concerns, please contact me Robin DeVito, 2805 St. Hwy 67, Fulton-Montgomery Community College, New York 12095 or fax to 518:762-6518, voice 518 – 736-3622 ext. 8145; email - rdevito@fmcc.edu. Your physician’s input is essential to the determination of appropriate accommodations.

Sincerely,

Robin DeVito
Academic Support Counselor-Accessibility Office

Enclosure: Disability Verification Form, Signed Release
I STUDENT INFORMATION

Last Name: ______________________________________  First Name: ____________________________
Social Security Number: __________________________ Date of Birth: ____________________________
Address: ______________________________________ Phone: ____________________________
City: ______________________________________ State: __________________ Zip: _________

II CERTIFYING PROFESSIONAL INFORMATION

Name & Credentials: ____________________________________________________________
Address: ______________________________________________________________________
City: ______________________________________ State: __________________ Zip: _________
License number and state of licenser: ______________________________________________

III DIAGNOSTIC DATA *(If psychological tests were administered, please include a copy of the report).

Please fill in a multiaxial DSM IV diagnosis with code and descriptor for each axis.

Axis I ________________________________________________________________
Axis II __________________________________________________________________
Axis III __________________________________________________________________
Axis IV __________________________________________________________________
Axis V Current GAF=_______________________________________________________

Current symptoms and history of presenting problem:___________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

History of hospitalization? ______YES ______NO
If yes, dates of hospitalization:______________________________________________

Does this person currently pose a threat to his/herself or others? ______YES ______NO
If yes, please explain:________________________________________________________
___________________________________________________________________________
IV  THERAPEUTIC INTERVENTIONS

Date of initial contact: ______________________ Date of last contact: ______________________

Therapeutic interventions and current plan for treatment: __________________________________
___________________________________________________________________________________

Is student compliant with therapeutic interventions? _______YES _______NO

Prognosis for treatment: _________________________________________________________________
___________________________________________________________________________________

Current medications including dosage and side effects: ______________________________________
___________________________________________________________________________________

Long-term medication plan: ______________________________________________________________
___________________________________________________________________________________

Is student compliant with medication plan? _______YES _______NO

V  IMPLICATIONS FOR THE COLLEGE ENVIRONMENT

Implications for academic success: _________________________________________________________
___________________________________________________________________________________

Implications for social interaction including residence life: ________________________________
___________________________________________________________________________________

Aspects of the college environment that may exacerbate symptoms: _________________________
___________________________________________________________________________________

___________________________________________________________________________________

Learning abilities specific to the post secondary environment that are impaired by the psychiatric disability (e.g. difficulty with concentration, slow processing speed etc.) ________________________________
___________________________________________________________________________________

Implications for taking exams and other classroom activities caused by the disorder or medications (please specify which): ________________________________
___________________________________________________________________________________

Implications for scheduling classes: ______________________________________________________
___________________________________________________________________________________

Other implications: ________________________________________________________________
___________________________________________________________________________________
VI SUGGESTED ACCOMMODATIONS

NOTE: Final determination of appropriate accommodations will be determined by the Academic Support Counselor based on consultation, as needed, with appropriate campus professionals (i.e., Counseling and Health Services) 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.

Extension of time to complete exams  
Rationale: ____________________________________________________________  
YES  NO

Quiet room in which to take exams  
Rationale: ____________________________________________________________  
YES  NO

Extension of a deadline to complete an assignment  
Rationale: ____________________________________________________________  
YES  NO

Modified class schedule (time of class, breaks)  
Rationale: ____________________________________________________________  
YES  NO

Reduced course load  
Rationale: ____________________________________________________________  
YES  NO

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:
Robin DeVito, 2805 St. Hwy 67, Fulton-Montgomery Community College, New York 12095 or fax to 518:762-6518, voice 518 – 736-3622 ext. 8145; email - rdevito@fmcc.edu

Disability Disclosure Psychiatric
Confidential  Page 4  3/14/2012