

VERIFICATION OF DISABILITY

McHenry County College Access and Disability Services provides accommodations for students with disabilities under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Amended Act (2008). In order to provide services, students must provide a verification of disability.

Student Information

Name

Preferred Name

Date of Birth

Email

Phone

Diagnosis

Certifying Professional—please provide the following information in full: attach test scores, reports, and other relevant information. If there is more than one disability, indicate which disability is primary and which is secondary.

Diagnosis:

Date of diagnosis:

Client currently under care?

Is the condition temporary (< 6 months) or persistent?

Briefly describe as appropriate the history of presenting symptoms and past functioning, duration of the disability, and relevant development, or historical data pertinent to the disability.

Major Life Activity Impacts

Please check each of the major life activities listed below that are affected by the diagnosis. Please indicate the severity of the limitations.

| Life activity | No Impact | Moderate Impact | Substantial Impact | Unknown |
|-------------------------|-----------|-----------------|--------------------|---------|
| Concentration | | | | |
| Memory | | | | |
| Social Interactions | | | | |
| Time management | | | | |
| Motivation | | | | |
| Performing Manual Tasks | | | | |
| Organization | | | | |
| Caring for oneself | | | | |
| Stress Management | | | | |
| Sleeping | | | | |
| Eating | | | | |
| Talking | | | | |
| Hearing | | | | |
| Seeing | | | | |
| Breathing | | | | |
| Standing | | | | |
| Walking | | | | |
| Lifting | | | | |
| Sitting | | | | |
| Learning | | | | |
| Reading | | | | |
| Writing | | | | |
| Other: | | | | |

Signature _____

Certifying Professional and Title (physician, psychiatrist, psychologist, licensed counselor)

Print Name _____

Address _____

Phone _____

Date _____

Access and Disability Services

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