Heartland Community College
Disability Support Services
Disability Verification Form
Revised 3/5/09

The student named below may be eligible for reasonable accommodations at this college. In order to provide services, we must have documentation of a disability that impairs one or more major life functions. This form can be submitted to Disability Support Services via fax at 309-268-7877 or mail at 1500 W. Raab Road, Normal, IL 61761.

TO BE COMPLETED BY THE STUDENT:
Student Name: ___________________________________________ Phone Number: _________________________________
Address: __________________________________________________________________________________________
Email: ___________________________________________________________________________________________

I hereby authorize the provider listed below to complete this form and provide information pertaining to my disability to Heartland Community College, Disability Support Services Office.

Student Signature: ___________________________________________ Date: _________________________________

TO BE COMPLETED BY A LICENSED PROFESSIONAL:
Name of provider (print): ___________________________________ Phone number: _______________________________

This portion of the form is to be completed by a licensed professional qualified to make the diagnosis for which the student is seeking accommodations. It cannot be completed by a practicing family member of the student. Please provide the following information in full (please be specific). This form is not valid unless there is a diagnostic statement given, a description of the disability is provided, functional limitations are listed, and it is signed and dated in the appropriate place.

Diagnostic Statement: __________________________________________________________

Description of the disability:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

For psychiatric disabilities, DSM IV-TR diagnosis or succeeding equivalent:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

For learning disabilities/ADHD, describe the diagnostic methods that were used?
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

In what settings or on what academic tasks will this disability likely manifest itself? Circle all that apply.
Classes  Assignments  Communication  Testing  Time Constraints
Attendance  Campus Mobility  Other: _________________________________

Appendix A
Functional Limitations within an academic setting:

____ limited ambulation  ____ visual acuity  ____ degree of hearing loss (__________)
____ substantial difficulty processing auditory information  ____ substantial difficulty concentrating
____ substantial difficulty memorizing information  ____ substantial difficulty using hands
____ substantial difficulty expressing self in writing  ____ substantial difficulty processing visual information
____ substantial difficulty performing math calculations  ____ easily distracted
____ substantial difficulty with organizational skills  ____ reading decoding  ____ reading comprehension

Services and accommodations that you would recommend for this student:

____ extended time on tests  ____ notetaker  ____ taped textbooks  ____ use of a computer
____ tape recorder  ____ reduced distraction testing environment  ____ sign language interpreter
____ scribe  ____ reader  ____ calculator  ____ preferential seating

Please list other accommodations you would recommend

Prescribed medications, dosage, side effects

The above mentioned disability (ies) is/are:

_____ Permanent/Chronic

_____ Temporary: ___ less than 45 days  ____ 45 plus days

Severity is:  ____ Mild  ____ Moderate  ____ Severe

I certify that all the information on this form is true and correct to the best of my knowledge.

Signature of Licensed Professional _______________________________  Date__________________________________
Title or License Type and Number  ______________________________________________________________________

If you have any questions, please feel free to contact Disability Support Services at 309-268-8259.