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

Psychiatric Disabilities (including ADHD/ADD and addiction/recovery)

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 DSM-V 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.

DSM-V Diagnosis(es):____

Does this condition substantially limit the student? Yes No

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

List major life activities that are limited: ____

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:

____

____

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)

____

(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