

Office of Disability Services
Bladen Community College
Disability Documentation Form

Student Full Name: _____ Student ID: _____

IMPORTANT: The Americans with Disabilities Act (ADA) and the ADA Amendments Act of 2008

(ADAAA) define a disability as a physical or mental impairment that substantially limits one or more major life activities. Thorough completion of this form is necessary for Disability Services to determine eligibility for accommodations. Insufficient information may result in delays or ineligibility. Complete one documentation form for each diagnosis or condition. Please note the following information:

- Any record provided to Disability Services becomes part of the student’s “education record” pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protections and access provisions of FERPA, the student has the right to inspect his or her own education records if requested.
- A learning disability diagnosis must be accompanied by a current, appropriate psycho-educational evaluation, including the diagnostic test scores.
- Visual or hearing loss documentation must include an acuity and/or audiology report that addresses the current impact of the disability, as well as information about the specific assistive technology used by the student.

TO BE COMPLETED BY DIAGNOSTICIAN OR TREATING PROFESSIONAL

Date of birth: _____

DSM-V or ICD diagnosis: _____

Date of initial diagnosis: _____ Date of most recent office visit: _____

Does this disorder substantially limit the student? Yes No

Attach any supporting documentation: e.g., psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc. **Supporting documentation attached**

Describe the student’s condition, symptoms, and the impact on life activities, including academics:

Treatments, medications, assistive devices/services currently prescribed or in use:

Will medication adversely impact this student, if so how?

Expected duration of the impact of the disability:

Temporary - Indicate anticipated recovery date: _____

Permanent

Chronic

Episodic/Recurring

Expected progression or stability of the impact of the disability:

Recommended accommodations related to disability, including those used in the past:

Name of Diagnostician/Professional: _____

Signature: _____ Date: _____

License #: _____

Organization: _____ Phone #: _____

Office of Disability Services
Bladen Community College
7418 NC Hwy 41W
Learning Enhancement Center - Building 8
Dublin, NC 28332
910.879.5586