

Disability Identification and Verification Forms

Applicants who are persons with disabilities, as defined in paragraph 104.3(j)(1)(i) of the regulation under Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Act (ADA) of 1990, may apply for admittance into the program. Taylor College will work with the applicant or student to provide necessary academic adjustments and auxiliary aids and services unless an adjustment would alter or waive essential academic requirements; fundamentally alter the nature of a service, program or activity; or result in undue financial or administrative burdens considering the College's resources as a whole.

Taylor College requires current and comprehensive documentation in order to determine appropriate services and accommodations. The outline below has been developed to assist the student in working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations.

- A. **The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified to do so.** These persons are generally trained, certified or licensed psychologists or members of a medical specialty.
- B. **All parts of the form must be completed as thoroughly as possible.** Inadequate information, incomplete answers and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.
- C. **The healthcare provider should attach any reports which provide additional related information** (e.g. psycho-educational testing, neuropsychological test results, etc.). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form. Please do not provide case notes or rating scales without a narrative that explains the results.
- D. **After completing this form, sign it, complete the Healthcare Provider Information section on the last page and mail or fax it to the College.** The information you provide will be kept in the student's file in the locked and secure file room, where it will be held strictly confidential. This form may be released to the student at his/her request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment.

If you have questions regarding this form, please contact the College's Section 504 Compliance Coordinator, Ms. Ingrid Zekan. Students may contact Ms. Zekan at 5190 SE 125th Street, Belleview, FL 34420, phone 352-245-4119, email: Ingrid.zekan@taylorcollege.edu. Students may request academic adjustments or auxiliary aids at any time.

STUDENT INFORMATION

Name (Last, First, Middle): _____

Date of Birth: _____ Last 4 Digits of SSN: _____

Cell phone: (____)-____-_____ Home phone: (____)-____-_____

Address (street, city, state and zip code): _____

E-Mail address: _____

DIAGNOSTIC INFORMATION *(Please Print Legibly or Type)*

1. What is the diagnosis, date of diagnosis, and last contact with the student?

2. Is the student/patient currently under your care? Yes / No (Please circle the correct response)

3. List current medications(s), impact, and adverse side effects.

4. If the student is currently undergoing medical treatment, please describe and indicate how the treatment might affect the student academically.

5. Major Life Activities Assessment: Please check which of the following major life activities listed below are affected because of the impairment. Please indicate severity of limitations.

Major Life Activity	1–Negligible	2-Moderate	3-Substantial
Talking			
Hearing			
Breathing			
Standing			
Caring for Oneself			
Reaching			
Lifting			
Sitting			
Walking			
Seeing			
Writing			
Performing Manual Tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Interacting with Others			
Other:			
Other:			
Other:			
Other:			

6. Describe how this medical condition may result in specific functional limitations in an academic setting (i.e., problems sitting for long periods of time, unable to type for more than ten minutes, or unable to walk more than 50 feet without fatigue)?

7. What is the expected duration of this disability?

8. Are there any situations or environmental conditions that might lead to an exacerbation of the condition?

HEALTHCARE PROVIDER INFORMATION

(Please sign & date below and fill in all other fields completely using PRINT or TYPE) all other fields completely using PRINT or TYPE)

Provider Signature: _____ Date: _____

Provider Name (Print): _____

Title: _____

License or Certification #: _____

Address: _____

Phone Number: (_____) - _____ - _____ FAX Number: (_____) - _____ - _____

Important: After documentation is reviewed, the Registrar will send an email notification to the student's email account acknowledging receipt of documentation and the eligibility status. Prospective students that do not have an email account will be notified via telephone.