Nashua Community College

ADA Verification Form

THIS FORM MUST BE COMPLETED & SIGNED BY A LICENSED PROFESSIONAL

NCC Student Name: _____ **Date of Birth:** _____

Professional's Name: _____

I am a: ___ Medical Dr. ___ Psychiatric Dr. ___ Licensed Counselor Other: _____

Practice Name: _____

Address_____

Phone _____ Fax _____

The above person is applying for disability services at NCC. To assist our office in making the most appropriate determination for accommodations, the following information is requested.

Please complete the entire form. If you have questions, call (603) 578-8996.

1. **Statement of Condition/Disability:** _____

_____

2. **Summary of assessment procedures/evaluations used to make the diagnosis:** _____

_____

3. **The listed Condition/Disability is**: _____ Permanent/Chronic: _____ Temporary:

   Severity is: _____ Mild _____ Moderate _____ Severe

4. **List all current medications/possible side-effects that could potentially impact academic performance**:

_____

_____

5. In your professional opinion, is this a condition that substantially ***limits one or more major life activities*** as defined by ADA standards (42 U.S. Code § 12102 - Definition of disability)**?** Major life activities are functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, ***learning*** and working**.**

*IN ORDER for a student to qualify for classroom accommodations in college, the professional must be able to say **YES** to the above statement.* ***CHECK ONE:*** _____ YES _____ NO

NCC Student Name: _____

6. **Functional Limitations within an *academic* setting (due to disability):**

_____ limited ambulation _____ visual acuity _____ hearing impairment [degree:_____]

_____ easily distracted _____ *severe* test anxiety _____ difficulty maintaining stamina/energy

7. **SUBSTANTIAL DIFFICULTY WITH:**

_____processing auditory information _____concentrating _____memorizing information

_____ use of hands _____expressing self in writing _____ processing visual information

_____ reading/decoding _____handling time pressures/multiple tasks _____ responding to change

_____responding to negative feedback _____ responding to authority figures **other:** _____

8. **Services and accommodations that you would recommend for this student that are SPECIFICALLY related to symptoms and diagnosis (please include rationale if needed):**

_____ extended time on tests _____ copies of notes _____ audio books

_____ extra time for clarification _____digitally record lectures _____ use of calculator

_____sign language interpreter _____scribe or reader for tests _____preferential seating

_____ physical breaks from class _____ meet with Coordinator weekly/bi/monthly

_____ reduced distraction testing environment **other:** _____

9. **List other accommodations that you might recommend and rationale:** _____

_____

Professional's Signature Required:

Name:_____

Signature:_____ **Date**:_____

Title/Credentials and License Number: _____

_____

Note: *Disability documents are kept separate from academics records are retained in the Disability Services Office.*

***Return this form to*:**

NASHUA COMMUNITY COLLEGE
Attn: Disability Services Office

Mail: 505 Amherst St.
Nashua, NH 03063

Email: jquinn@ccsnh.edu

Fax: (603) 883-1636

Phone: (603) 578-8996