Verification Form for Physical or Psychiatric Conditions

Name of NCC Student: ___________________________________________ Date of Birth: _____________

To: Professional’s name: ___________________________________________ Today’s date: _____________

Are you: _____ Medical  _____ Psychiatric  _____ Counselor  _____ Other: ____________________

Practice Name: ______________________________________________________

Address _______________________________________________________________________

Phone & Fax ____________________________

The above person is applying for services from the Disability Services Center at NCC. To help our office make the most appropriate determination of accommodations, the following information is requested. Please print clearly and complete form completely. If you have questions, please call (603)578-8900 ext1451. Thank you for your cooperation!

1. Statement of Conditions/Disability(ies):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Summary of assessment procedures/evaluations used to make the diagnosis:________________________
____________________________________________________________________________________

2. The above mentioned disability(ies) is/are: _____ Permanent/Chronic  _____ Temporary:

   Severity is: _____ Mild  _____ Moderate  _____ Severe

3. Please list all current medications, and possible side-effects that could potentially impact academic performance:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

4. In your professional opinion, is this a condition that substantially limits one or more major life activities; as defined in the ADA? Major life activities means functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. Please circle:  YES   NO

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

   ____ limited ambulation  ____ visual acuity  ____ degree of hearing loss (___________)

   ____ easily distracted  ____ severe test anxiety  ____ difficulty maintaining stamina/energy

   SUBSTANTIAL DIFFICULTY WITH:

   ____ processing auditory information  ____ concentrating  ____ memorizing information  ____ using hands

   ____ expressing self in writing  ____ processing visual info  ____ performing math calculations

   ____ organizational skills  ____ reading comprehension  ____ reading decoding

   ____ handling time pressures and multiple tasks  ____ responding to change

   ____ responding to negative feedback  ____responding to authority figures  ____ Other: _________________

**Please continue to other side**
6. 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
- reduced distraction testing environment
- scribe or reader for tests
- use of calculator
- preferential seating
- meet with Coordinator weekly/bi/monthly
- physical breaks from class
- sign language interpreter

Please list other accommodations that you might recommend and rationale: ________________________________

___________________________________________________________________________________________

___________________________________________________________________________________________

Please sign and date below, as well as indicate your title and credentials

Name:____________________________________________________________________________________

Signature:_____________________________________ Date:________________________________________

Title/Credentials and License No:________________________________________________________________

Note: Disability documents are kept separate from academics records in a locked file cabinet in the disability services office.

Please return this form to:
Disabilities Support Coordinator, Nashua Community College
505 Amherst St. Nashua, NH 03063
603-578-8996. Fax: 882-8690