

**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: \_\_\_\_\_

**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