CAPE COD COMMUNITY COLLEGE
O'NEILL CENTER FOR STUDENT ACCESS AND SUPPORT

2240 Iyannough Rd. West Barnstable, MA 02668-1599
(774)-330-4337 (508)-375-4110 (fax)

VERIFICATION OF MEDICAL OR PHYSICAL DISABILITY

DATE: _____

TO: _____
(Name of Appropriate Practitioner)

FROM: Douglas Terry
Coordinator, O'Neill Center
Student Access and Support
774-330-4337
dterry@capecod.edu

_____ is a student at Cape Cod Community College who is requesting academic accommodations/services through our office. To determine this student's eligibility for academic accommodations under the Americans with Disabilities Act, and to ensure the provision of such services, the college requires documentation of the disability. Your assistance in furnishing pertinent medical or physical information that would enable us to accurately assess this student's specific accommodations would be greatly appreciated. ***NOTE: See reverse side of this form for questionnaire to be completed by an appropriate practitioner.***

Student authorization to release information

I hereby authorized the above-named physician to release information regarding my disability to the O'Neill Center at Cape Cod Community College. I understand that the information will be used for documentation of my disability and to ensure the provision of reasonable and appropriate services. Furthermore, I understand all information provided will be held in strict confidence as specified in the rules and regulations of Cape Cod Community College.

Student Signature: _____ Date: _____

Patient's name: _____

Information to Document Medical or Physical Disability

To Be Completed by Physician or Appropriate Medical Personnel

1. **ICD or DSM-V/DSM-IV Classification:** _____

2. ICD or DSM-V/DSM-IV Criteria (symptoms) related to diagnostic category.
   (Describe the symptoms, severity and longevity of the condition related to and that substantiate the diagnostic category.)

3. Date of onset, last date patient seen, type of evaluation conducted:

4. Please indicate any major life activities that are affected because of the diagnosis. Indicate the level of limitation:

5. List medications and any side effects that maybe important in developing an accommodation plan:

6. You may offer *suggestions* for appropriate and reasonable accommodations at the post-secondary educational level:

Signature: _____ Date: _____

Print Name and Title: _____

Address: _____

_____ Phone:_____

Email: _____