ILLINOIS VALLEY
COMMUNITY COLLEGE

IVCC Center for Accessibility & Neurodiversity

Verification of a Physical or Medical Disability

A patient/client of yours has requested disability-related services from the Center of Accessibility & Neurodiversity (CAN) at IVCC. Legal protection and eligibility for such services is based on an individual providing sufficient information to conclude that he/she/they has an impairment that substantially limits one or more major life activities. As this student's treating specialist, you are asked to provide the following information to allow the IVCC Center for Accessibility & Neurodiversity to consider the student's request for accommodations.

Illinois Valley Community College (IVCC) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Amendments Act of 2008 (PL 110-325) to provide effective auxiliary aids and services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to IVCC's programs and services. Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. It is important to note that a diagnosis in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

IMPORTANT: Filling this form out in a *timely* and *thorough* manner is vital to providing reasonable accommodations for students. If you have any questions regarding the nature of the information needed for students, please call the IVCC Center for Accessibility & Neurodiversity Coordinator, Tina Hardy, at 815-224-0284 or email her at tina_hardy@ivcc.edu.

Student Section – To be filled out by the student

Please have your healthcare professional provide the following information. *This form must be completed in full or it will be returned to you.*

First Name: _____ MI: _____ Last Name: _____

Student ID: _____ DoB: _____ Ph #: _____ C H

Full Address: _____

Email: _____

Section for Healthcare Professional

*Note to Healthcare Professional – You may attach additional documentation or paper as needed for any questions below.

1. DIAGNOSTIC STATEMENT IDENTIFYING THE CONDITION

Please include a clear diagnostic statement that identifies the type of condition, describes how the condition was diagnosed, provides information on the functional impact, and details the typical progression or prognosis of the condition.

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_____
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2. DESCRIPTION OF THE DIAGNOSTIC METHODOLOGY USED

Please provide a description of the diagnostic criteria, evaluation methods, procedures, tests, and dates of administration, as well as a clinical narrative, observation, and specific results.

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3. DESCRIPTION OF THE CURRENT FUNCTIONAL LIMITATIONS

Please include information on how the condition currently impacts the individual. A combination of the results of formal evaluation procedures, clinical narrative, and the individual's self report is the most comprehensive approach to fully documenting impact. The best quality documentation is thorough enough to demonstrate whether and how a major life activity is substantially limited by providing a clear sense of the severity, frequency, and pervasiveness of the condition.

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4. DESCRIPTION OF THE EXPECTED PROGRESSION OR STABILITY OF THE CONDITION

Please provide information on expected changes in the functional impact of the condition over time and context. Information on the cyclical or episodic nature of the condition and known or suspected environmental triggers to episodes provides opportunities to anticipate and plan for varying functional impacts. If the condition is not stable, information on interventions (including the individual's own strategies) for exacerbations and recommended timelines for re-evaluation are most helpful.

5. DESCRIPTION OF CURRENT & PAST ACCOMMODATIONS, SERVICES, AND/OR MEDICATIONS

Please include a description of current medications, auxiliary aids, assistive aids, assistive devices, support services and accommodations, including their effectiveness in ameliorate functional impacts of the condition.

6. RECOMMENDATIONS FOR ACCOMMODATIONS, ADAPTIVE DEVICES, ASSISTIVE SERVICES, COMPENSATORY STRATEGIES, AND/OR COLLATERAL SUPPORT SERVICES

It is most helpful when recommended accommodations and strategies are logically related to functional limitations.

7. PLEASE INDICATE THE LEVEL OF LIMITATIONS/IMPACTS FOR THE FOLLOWING MAJOR LIFE ACTIVITIES:

Major Life Activity	**No Impact or Limitation**	**Mild Impact or Limitation**	**Substantial Impact or Limitation**
Caring for oneself			
Talking			
Hearing			
Breathing			
Seeing			
Walking/Standing			
Lifting/Carrying			
Sitting			
Performing Manual Tasks			
Eating			
Working			
Interacting with Others			
Sleeping			
Gross Motor Skills			
Fine Motor Skills			

8. PLEASE INDICATE THE LEVEL OF LIMITATIONS/IMPACTS FOR THE FOLLOWING ACADEMIC LEARNING ACTIVITIES:

Major Life Activity	**No Impact or Limitation**	**Mild Impact or Limitation**	**Substantial Impact or Limitation**
Reading			
Writing/Spelling			
Calculating			
Memorizing			
Concentrating			
Walking/Standing			
Listening			
Timely submission of assignments			
Attending class regularly			
Being on time for class			
Organization			

This section to be completed and signed only by the certified licensed professional:

Name: _____ Credentials: _____

Address: _____

City *ST* *Zip*

State of Licensure: _____ License/Certification number: _____

Date of **initial** contact with student: _____

Date of **last** contact with student: _____

_____ _____

Signature of Certified Licensed Professional **Date**

This form should be returned to: IVCC Center for Accessibility & Neurodiversity
ATTN: Tina Hardy
815 N. Orlando Smith Road
Oglesby, IL 61348-9692

OR faxed to 815-224-0295 ATTN: Tina Hardy