ROBESON COMMUNITY COLLEGE

Post Office Box 1420; 5160 Fayetteville Rd.
Lumberton, North Carolina 28359
Phone: (910) 272-3700 www.robeson.edu

Office of Counseling and Career Services
Disability Services Verification Form

The Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment or is regarded as having such impairments. Accommodation requests must be consistent with documentation submitted.

Thorough completion of this form is necessary for the office of Disability Services to determine eligibility for accommodations. Insufficient information may result in delays or ineligibility.

To Be Completed by Diagnostician or Treating Professional

I. DIAGNOSIS

Student Name: _____ DOB: _____

Diagnosis: _____ DSM-V or ICD Code: _____

Date of diagnosis: _____ Date of most recent office visit: _____

Does this disorder substantially limit the student? ☐ Yes ☐ No

Describe the student's condition, symptoms, and impact of life activities to include academics:

Expected duration of the impact of the disability:

- ☐ Temporary – Indicate anticipated recovery date: _____
- ☐ Permanent
- ☐ Chronic
- ☐ Episodic/Recurring

Expected progression or stability of the impact of the disability:

Attach supporting documentation of the disability: e.g. psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc. and submit to the office of Counseling & Career Services at Robeson Community College. Please direct questions to kjacobs@robeson.edu or (910) 272-3353.

II. TREATMENT

Provide a list of medications, treatments, assistive devices/services currently prescribed or in use:

Medications	**Medication Effects/Side Effects/Adverse Impacts**
Services/Treatments	**Assistive Devices**

III. RECOMMENDATIONS

List below the substantial functional limitations (e.g. easily distracted, poor concentration, difficulty formulating and executing plan(s) of action) and your recommended reasonable accommodations (e.g. extended test time, priority seating, separate testing, etc.). Reasonable accommodations must be consistent with documentation.

Sub. Functional Limitation	**Reasonable Accommodation**	**Frequency/Duration**

Name of Diagnostician/Professional: _____

Signature: _____ Date: _____

License Number: _____ State: _____

Organization/Business Address and Phone Number:

_____

_____

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