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Disability Support Services ♦ 10901 Little Patuxent Parkway ♦ Columbia, MD 21044  
Tel: 443.518.1300 ♦ Fax: 443.518.4499 [disabilitysupport@howardcc.edu](mailto:disabilitysupport@howardcc.edu)

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**DISABILITY VERIFICATION FOR STUDENTS  
WITH A MEDICAL OR PHYSICAL CONDITION**

The student/patient named below has asked to register with Disability Support Services (DSS) at Howard Community College. DSS requires documentation of the individual's disability in order to establish eligibility and provide services.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a disability exists and the disability substantially limits one or more major life activities. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and academic adjustments.

After completing this form, please fax or email it to the DSS fax number or email address listed above. The information you provide will not become a part of the student's educational records but will be kept in the student's file at DSS where it will be kept confidential. Please contact DSS if you have questions or concerns. Thank you for your assistance.

**ITEMS 1-4 TO BE COMPLETED BY STUDENT:**

1. Name of Student: \_\_\_\_\_
2. Student Date of Birth: \_\_\_\_\_
3. Today's Date: \_\_\_\_\_
4. Student Signature: \_\_\_\_\_

**ITEMS 5-13 TO BE COMPLETED BY MEDICAL PROFESSIONAL:**

5. What is the diagnosis/impairment? \_\_\_\_\_
6. Date of diagnosis: \_\_\_\_\_
7. Date of last visit: \_\_\_\_\_
8. Duration of disability/impairment:  
 Permanent     Temporary: Expected date of recovery: Mo./Yr.: \_\_\_\_\_

9. Please check the major life activities and academic functions listed below that are affected by the disability/impairment in a college setting, indicating the level of limitation.

Life Activity	Negligible	Moderate	Substantial	Life Activity	Negligible	Moderate	Substantial
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attending Class	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meeting Deadlines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Interacting with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Describe current symptoms that may affect the individual's ability to perform a college setting.

11. If the individual is currently undergoing treatment or taking medication, please describe how it may affect his/her academic performance.

12. Please provide information you think will be helpful in determining reasonable academic accommodations and services for this individual (e.g., note-takers, extended time for test, etc.)\*

**13. CERTIFYING PROFESSIONAL:**

Medical Professional's Name and Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

*\* Tests of cognition, information processing and academic achievement, which may not have been part of the diagnostic process itself, may be needed by DSS to determine appropriate academic accommodations and services for a student with mobility impairment or other impairment due to a medical condition.*