DISABILITY VERIFICATION FORM (Form 1)
Medical Provider Verification

Dear Health Care Professional,

One of your patients is a student at Lone Star College requesting a disability-based academic accommodation. Accommodations are made for qualified students with a disability in order for them to equally participate in all programs and services offered by the College to ensure compliance with all applicable disability laws. In order for the Disability Services Office to determine the student's accommodation eligibility, we need your clinical assessment/diagnosis of the student. You may fax us a copy, but our records must include an original with your signature and business card. In addition to the form provided, you may provide supplemental information on your letterhead.

In order for the student to be certified as eligible, the documentation must show how the disability substantially limits one or more major life activities. Current and relevant information is required in order to determine the appropriate reasonable accommodation that may be offered to the student.

All information should be completed by a medical provider qualified to diagnose and treat the student's disability.

Please provide the following:

(a) A completed and signed Provider Verification packet for each disability and
(b) Your business card stapled to each Provider Verification packet.

The information you provide will be kept confidential in accordance to the Family Education Rights and Privacy Act (FERPA) and may be released to the student upon written request for records.

If you have any questions regarding this form or opportunities for the student, please contact Disability Services at the information listed below. We may also contact you directly for supplemental information if necessary to make a determination

Thank you for your assistance,

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*The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual except as specifically allowed by this law. To comply with this law, **we are asking that you not provide any genetic information when responding to this request for medical information**. "Genetic information", as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought of received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Provider Verification of Physical/Medical Disability

Student Name: _____ Student ID: _____

To the Student: **The form below the line must be completed by your medical provider** who is qualified to diagnose and treat your disability. The Disability Services Office reserves the right to request additional documentation or contact your provider for additional information. If this form is completed by anyone other than a qualified licensed profession, the information will not be used to support your accommodation request. Inaccurate and incomplete documentation may hinder the College's ability to accommodate you based on its policies and procedures.

Please sign the box below to give your medical provider authorization to release information to the Disability Services Office.

I, _____, authorize my medical provider to release to Lone
Printed Student Name
Star College's Disability Services Office the medical information requested on this form for the purpose of determining appropriate accommodations for my disability while a student at Lone Star College.

Patient Signature: _____ Date: _____
Student Signature

TO BE COMPLETED BY MEDICAL PROVIDER

Is the student currently under your care? ☐ No ☐ Yes If yes, for how long? _____

_____

What is the diagnosis/impairment/condition? (Please describe and use ICD 10 diagnostic codes and or APA DSM 5)

_____

_____

_____

_____

_____

Date(s) of Onset: _____

A. FUNCTIONAL LIMITATION CHART

Reminder: Please identify functional limitations without regard for mitigating measures (i.e., medications). For intermittent conditions, assess functional limitations based on a picture when all symptoms are active. Use an "X" to indicate level of impact on major life activities.

Major Life Activities	**No Impact**	**Moderately Impacts**	**Substantially Impacts**	**Unknown**
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Sitting				
Other:				

What are the specific functional limitations resulting from the disability's impact on the major life activities in a learning environment (e.g. unable to handle stairs, miss class due to side effects from disability or medication, unable to sit for long periods of time)? _____

_____

_____

Are the functional limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

B. FUNCTIONAL OR BEHAVIORAL PRESENTATION CHART

Please use an "X" to indicate additional limitations or behavioral manifestations.

Limitations and Behavioral Manifestations	**Not an Issue**	**Moderate Issue**	**Substantial Issue**	**Unknown**
Cognitive Processing				
Memory				
Processing Speed				
Meeting Deadlines				
Attending class				
Organization				
Reasoning				
Stress				
Sleep				
Appetite				
Other:				

What are the specific behavioral limitations resulting from the disability's impact on the major life activities in a learning environment? _____

_____

_____

Are the behavioral limitations permanent? ☐ No ☐ Yes If no, what is the anticipated date of resolution? _____

_____

Is the student currently undergoing treatment? ☐ No ☐ Yes If yes, please describe the type of treatment and list any medications and possible side effects that may affect the student in an academic setting: _____

_____

_____

_____

Medical Provider Information:

First Name: _____ Last Name: _____

Title: _____ State License Number: _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____ Fax: _____

Physician/Provider Signature: _____ Date: _____

PLEASE ATTACH BUSINESS CARD HERE

STUDENT INFORMATION & DISABILITY ACCOMMODATION REQUEST (Form 2)

Accommodations Requests also include requests for Auxiliary Aids and Services

Student Information:

Name:_____

Student ID:_____ Date of Birth: _____

Address: _____

Primary telephone: _____ Email: _____

Do you give permission to leave confidential information on voicemail? Y __ N __

Would you like to receive email updates and reminders from our office? Y __ N __

Emergency Contact Information (optional):

_____

Date_____

Semester _____

Year _____

Are you currently enrolled at Lone Star College? Y __ N __

If yes, check campus:

- ☐ Cy-Fair
- ☐ Kingwood
- ☐ Cypress Center
- ☐ Montgomery
- ☐ North Harris
- ☐ Aldine Center
- ☐ Tomball
- ☐ Creekside
- ☐ University Park
- ☐ Conroe Center
- ☐ Greenspoint Center
- ☐ Fairbanks Center
- ☐ Victory Center
- ☐ Atascocita Center
- ☐ Other _____

If no, when will you enroll and where? _____

Career Goal or Major: _____

Disability Information:

What is your disability or disabilities? _____

_____

Check All That Apply:

- ☐ Learning Disability
- ☐ Asperger's/Autism
- ☐ Deaf/Hard of Hearing
- ☐ Mental Health
- ☐ Blind/Low Vision
- ☐ Traumatic Brain Injury
- ☐ Physical/Mobility
- ☐ Other _____
  _____
  _____

What accommodations will assist you in your academic life? _____

_____

Check all support you receive and list corresponding contact information:

- ☐ DARS (Department of Assistive and Rehabilitative Services)
- ☐ VA
- ☐ MHMR (Mental Health Services)
- ☐ OTHER _____

Agency Name: _____
Contact Name: _____
Telephone: _____
Agency Name: _____
Contact Name: _____
Telephone: _____

STUDENT AGREEMENT REGARDING DISABILITY ACCOMMODATION REQUESTS

Please read carefully and initial each statement below indicating your agreement:

_____I understand that I must submit a request for accommodation and provide requested documentation of my disability to the Disability Services Office at the college where I am enrolled in order to be eligible to receive accommodation(s).

_____I understand that accommodation requests with approved documentation may take 2-4 weeks to be processed and, if possible, implemented by the College.

_____I understand that, for the Disability Services Office to provide effective accommodation(s) for me, information related to my enrollment, courses, and disability will be used by the Disability Services Office for purposes of preparing or providing reasonable accommodation.

_____I consent to the College's Disability Services Offices to communicate regarding my disability as it pertains to my accommodations, educational needs, and progress.

_____I consent to the Disability Services Offices to communicate with my instructors regarding proposed or approved accommodation(s), my educational needs, and progress reports as needed. Unless specifically requested in writing, the Disability Services Office will not communicate my disability outside of personnel in the College's Disability Services Office.

_____I understand that I must meet with the Disability Services Office each semester I am enrolled to be eligible to receive accommodation(s).

_____ _____

Student Signature Date

For Disability Services Office Use Only:

Did student provide and attach requested documentation to be eligible for accommodation? Y ____ N _____
If no, was student provided with a Disability Verification Form and reminded of his or her responsibility to obtain said documentation prior to being eligible for accommodation? Y____ N____

Did Disability Services provider and student discuss the student's class schedule and specify which courses he or she desired accommodation(s) for? Y____ N____

DSO Provider: _____ Date: _____

STUDENT REQUEST FOR CONTINUED SERVICES (Form 3)

This Form is for students who have previously completed the College's two-step process for receiving accommodation from the Disability Services Office (DSO). If you have not completed the College's two-step process, please use the Student Information & Disability Accommodation Request (Form 2). Please note that submission of this form does not automatically grant accommodation. Once submitted, a DSO provider will review this Form and determine whether the you are eligible for accommodation. Eligible students will receive an accommodation letter from the DSO for the current semester.

Student Information:

Name:_____ Today's Date: _____

Student ID:_____ Date of Birth: _____

Address: _____

Primary telephone: _____ Email: _____

When did you receive accommodation at Lone Star College? Semester _____ Year _____

College of enrollment:

- ☐ Cy-Fair
- ☐ Kingwood
- ☐ Cypress Center
- ☐ Montgomery
- ☐ North Harris
- ☐ Aldine Center
- ☐ Tomball
- ☐ Creekside
- ☐ University Park
- ☐ Conroe Center
- ☐ Greenspoint Center
- ☐ Fairbanks Center
- ☐ Victory Center
- ☐ Atascocita Center
- ☐ Other _____

Disability Information:

Has your disability changed? Y _____ N _____

If Yes, please explain:_____

_____

_____

Are you submitting updated documentation? Y _____ N _____

Are you requesting the same accommodation(s) previously granted by the College? Y _____ N _____

If No, please explain:_____

_____

_____

Is your current class schedule attached? Y _____ N _____

STUDENT AGREEMENT REGARDING CONTINUED SERVICES REQUESTS

Please read carefully and initial each statement below indicating your agreement:

_____I understand that I must submit a request for continued services to the Disability Services Office be eligible to receive previously granted accommodation each semester.

_____I understand that changes to my disability or my previously granted accommodation may require me to provide additional or updated documentation.

_____I understand that changes to my disability or my previously granted accommodation may take 2-4 weeks to be processed and, if possible, implemented by the College.

_____I understand that, for the Disability Services Office to provide effective accommodation(s) for me, information related to my enrollment, courses, and disability will be used by the Disability Services Office for purposes of preparing or providing my reasonable accommodation.

_____I consent to the College's Disability Services Offices to communicate regarding my disability as it pertains to my accommodations, educational needs, and progress.

_____I consent to the Disability Services Offices to communicate with my instructors regarding proposed or approved accommodation(s), my educational needs, and progress reports as needed. Unless specifically requested in writing, the Disability Services Office will not communicate my disability outside of personnel in the College's Disability Services Office.

_____ _____

Student Signature Date

For Disability Services Office Use Only:

Did student attach class schedule? Y ____ N _____

Are students previously provided accommodations reasonable for the current classes? Y _____ N _____

Did student have a change in disability? Y _____ N _____

If yes, did student provide additional or updated documentation? Y _____ N _____

Did student request a change in the previously provided accommodation(s)? Y _____ N _____

If yes, does the change requested require additional or updated documentation? Y _____ N _____

DSO Provider: _____ Date: _____

Request for Reconsideration (Form 4):

This request must be sent to the Executive Director of Disability Services

Student: _____
Print Name

Student ID: _____

Disability Services Office: _____
College campus

This Request for Reconsideration is for (circle one):

Accommodation Denial or College-proposed Accommodation

Request for Reconsideration – Please describe the circumstances of your request for reconsideration. Attach all relevant documentation including the Disability Services Office denial of accommodation or your accommodation letter. _____

_____

_____

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