Student Disability Services

NORTH CENTRAL COLLEGE 1861

Business and Entrepreneurship Building Room 152
Phone: 630-634-5264 | Fax: 630-637-5462
sds@noctrl.edu

Disability Verification

STUDENT INFORMATION

Last Name _____ First Name _____

Middle Initial _____ Date of Birth _____

Student ID _____ Year in school at NCC _____

Phone _____ Email _____

Street Address _____

City _____ State _____ Zip _____

PROVIDER INFORMATION

Name _____ Degree _____

License # _____ Title _____

Phone _____ Fax _____

Email _____ or Website _____

Street Address _____

City _____ State _____ Zip _____

Information released includes any confidential information to further support the request for accommodations. This information is used for the purpose of determining reasonable accommodations while the above student is attending North Central College.

By signing below, I certify all information is true and accurate to the best of my professional knowledge/opinion.

- I have diagnosed and/or I am currently treating the individual requesting this information for the health condition stated on this form.
- The listed health condition meets the criteria to be classified as a disability as defined by the Americans with Disabilities Act.
- I am not a family member and/or do not have a conflict of interest with this individual that would make it unethical to complete this form.

Provider Signature _____ Today's Date _____

DISABILITY INFORMATION

Please state the disability/disabilities (including ICD & DSM codes):

Date of diagnosis _____ Date of last contact with student _____

Which major life activities (which includes but is not limited to caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working) are impacted and to what severity (no impact, mild, moderate, or severe).

Describe the expected duration or progression of the disability and situations or environmental conditions that may exacerbate the student’s symptoms.

Please describe the medications or treatment the student is prescribed including the effectiveness and potential side effects.

Describe how the disability may impact the student in an academic, residential or dining setting.

Please list any accommodations that may best meet the needs of the student under Section 504 and 508 of the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990 and the ADA Amendments Act of 2008.

Provider Signature _____ Date _____