Reynolds COMMUNITY COLLEGE

Office of Student Accommodations Certification Form

Section A: To be completed by Student

Student Name: _____ **Student ID:** _____
Last First (MI)

Address_____**Phone** _____

IMPORTANT: The Americans with Disabilities Amendment Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Thorough completion of this form is necessary for Office of Student Accommodations to determine eligibility for accommodations. Insufficient information may result in ineligibility. ***Complete one documentation form for each diagnosis or condition.*** Please note the following information:

☐Any record provided to Disability Services becomes part of the student's "education record" pursuant to the Family Educational Rights and Privacy Act (FERPA). Under the privacy protections and access provisions of FERPA, the student has the right to inspect his or her own education records if requested.

☐A learning disability diagnosis must be accompanied by a current, appropriate psycho-educational evaluation, including the diagnostic test scores.

☐Visual or hearing loss documentation must include an acuity and/or audiology report that addresses the current impact of the disability, as well as information about the specific assistive technology used by the student.

Consent to be signed by student.

I, _____, authorize a release of information, allowing the Office of Student Accommodations at Reynolds Community College to contact the diagnosing professional completing this form to obtain additional information or clarification to determine reasonable accommodations.

_____ _____
Signature **Date**

Sections B-F to be completed by diagnosing professional:

Section B:

TO BE COMPLETED BY DIAGNOSTICIAN OR TREATING PROFESSIONAL

(Please check one)

☐ADHD/ADD ☐Medical ☐Psychological ☐Learning Disability

Date of Birth: _____

DSM-5 or ICD diagnosis: _____

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

Does this disorder substantially limit the student? ☐**Yes** ☐**No** Is the Student in treatment ☐**Yes** ☐**No**

Has the student been recently hospitalized ☐**Yes** ☐**No** **if yes, Date**_____

Attach any supporting documentation: e.g., psycho-educational evaluations for learning disabilities, audiology reports, vision reports, etc.

Expected duration of the impact of the disability:

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

☐**supporting documentation attached**

Section C:

Check ALL administered assessments

☐**Neuropsychological Evaluation** Date(s) of Testing: _____
☐Name of Instrument: _____

☐**Psycho-educational Evaluation** Date(s) of Testing: _____
☐Name of Instrument: _____

☐**Psychological Evaluation** Date(s) of Testing: _____
☐Name of Instrument: _____

Section D:

Provide history for the following areas:

Behavioral _____

Developmental _____

Educational _____

Medical _____

Psychological _____

Describe the student's condition, symptoms, and impact on life activities, including academics:

_____

_____

_____

_____

Treatments, medications, assistive devices/services currently prescribed or in use:

_____

_____

Will medication adversely impact this student, if so how?

_____

_____

Section E:

Has the student used accommodations in the past ☐Yes ☐No , if yes, please indicate

_____

Recommended accommodations related to disability

_____

_____

Section F:

Name of Diagnostician/Professional: _____

Signature: _____ Date: _____

License #: _____State_____

Organization: _____Phone #: _____

Address: _____

Please attach a copy of your business card and submit the accompanying report to:

Office of Student Accommodations
Reynolds Community College
P.O. Box 85622
Richmond, VA 23285-5622
Email: OSA@reynolds.edu
Phone (804) 523-5290
Fax: (804) 523-371-3527
Voice/TDD: VA replay 711