Nunez Community College Disability Services Office
PHYSICAL AND SYSTEMIC (MEDICAL) DISABILITY DOCUMENTATION REQUEST FORM

***This form must contain ALL of the REQUESTED INFORMATION and be TYPED or PRINTED in order to apply for accommodations through the Disability Services Office.***

Student’s Name:  ______________________________________________________________________
Date of Birth:  ________________________________________________________________________
Address:  _______________________________________
Phone Number:  ______________________________________________________________________
Student ID# :  _________________________________________________________________________

This student is requesting an auxiliary aid or service, academic adjustment, and/or other accommodations from Office of Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate auxiliary aids and services, University Policy requires that a Qualified Professional provide current and comprehensive documentation. A qualified professional includes a medical doctor or other qualified healthcare professional who is not a family member of the student. IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL’S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM DISABILITY SERVICES.

The documentation provided must include information that diagnoses a physical or systemic (medical) disability, describes the functional limitations in an educational setting, indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication along with any current side-effects which may impact academic performance.

If it is a visual disability the documentation must include the student’s visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged text is recommended as an accommodation.

To facilitate the gathering of such critical information, please respond to the following and return to BRCC, Office of Disability Services.

1. Diagnosis  _______________________________________________________________________

2. Date of Diagnosis:  _______________  Date of Last Contact with Student:  _______________

3. Provide a summary of the student’s educational, medical, and family history that relates to the physical or systemic (medical) disability (difficulties must be related to the diagnosed disability and are not the result of other conditions, cultural differences, or insufficient instruction):
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________
   _______________________________________________________________________

Effective July 2012
4. Describe the student’s functional limitations in an educational setting:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

5. List current medication along with any current side-effects which may impact academic performance:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

6. Please indicate the RECOMMENDATIONS you have regarding necessary and appropriate auxiliary aids or services, academic adjustments or other accommodations to equalize the student’s educational opportunities at BRCC as justified based on the functional limitations indicated above.

Please check all that apply: ___ extended time (1.5x) ___ distraction-reduced environment
___ alternative test format ___ consideration for absences ___ no scantron ___ class notes
___ books on tape ___ enlarged text (font size ___ ) ___ reader ___ scribe
___ other (describe below) __________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

Qualified Professional’s Signature: __________________________________________________
Printed Name & Title: _____________________________________________________________
Daytime Telephone Number: _____________________________________________________
Address: ______________________________________________________________________
Date: _______________________________________________________________________

NOTE: Our policy regarding documentation prohibits the dissemination of documentation to you or anyone requesting it once it is received. Therefore, once this form is submitted, we will be unable to disseminate copies to anyone.