DISABILITY ACCOMMODATIONS FOR STUDENTS

The student named below has asked to register with Disability Support Services (DSS) at Frostburg State University. DSS requires documentation of the student’s disability in order to establish eligibility and provide services.

This evaluation form must be completed by a licensed healthcare or mental health professional including a physician, nurse practitioner, psychiatrist, clinical psychologist, clinical social worker, or professional counselor.

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 confidential file at DSS. Please contact DSS if you have concerns or questions. Thank you for your assistance.

ITEMS 1-3 TO BE COMPLETED BY STUDENT:
1. Name of Student: _______________________________________________________
2. Student Date of Birth: _______________________________________________
3. Student Signature/Date: ______________________________________________

ITEMS 4-10 TO BE COMPLETED BY CERTIFYING PROFESSIONAL:
4. Date of Diagnosis: ___________ Date of last visit: _________________________
5. ICD 10 or DSM-5 diagnoses:
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________
   ______________________________________________________________________

__________________________________________________________________________
6. Are there any coexisting conditions, including other disabilities, or medication side effects that should be considered when providing accommodations?

____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________

☐ Interview with the person him/herself ☐ Neuro-psychological testing
☐ Interview with other persons ☐ Psycho-educational testing
☐ Behavioral history ☐ Educational testing
☐ Developmental history ☐ Medical history
☐ Educational history

Comments:

____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________
____________________________________________________________________________________________________________________________________

Please attach copies of testing reports if available.

8. Please check below the major college life activities that are affected to a substantial degree because of the disability.

☐ Eating ☐ Classroom group functioning
☐ Sleeping ☐ Regular class attendance
☐ Learning ☐ Managing deadlines
☐ Organization ☐ Stress Management
☐ Focusing or concentrating ☐ Test-taking
☐ Social interactions ☐ Memory
☐ Reading ☐ Other (please specify)
☐ Writing
9. Please indicate your recommendations regarding academic, testing, and/or housing accommodations and accompanying justifications for this student. See next page for common accommodations.

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<th>Accommodation</th>
<th>Justification</th>
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10. CERTIFYING PROFESSIONAL*:

________________________________________________________________________

Printed Name/Degree/Field

________________________________________________________________________

Signature  Date

________________________________________________________________________

License Number  Telephone  Fax

________________________________________________________________________

Street  City  State  Zip
All reasonable, justified requests for accommodations made by a qualified healthcare or mental health professional will be considered by Disability Support Services. Commonly requested accommodations are listed below.

**Common Testing Accommodations**

- Extended time to complete tests, quizzes, and other timed assignments
- Low-distraction testing environment
- Isolated testing environment
- Alternate test form (e.g., braille, reader/taped exam, scribe/dictated exam)
- Basic function calculator
- Increased font

**Common Classroom Accommodations**

- Specified seating (e.g., near exit, near professor)
- Option to record lectures
- Note-taking services
- Alternative texts (e.g., audio, braille)
- Software/hardware (e.g., use of tablet, smart pen, adaptive/assistive technology)
- Attendance considerations
- Captioned films/videos
- Interpreter services (e.g., sign language)
- Magnification devices
- Accessible desks/table

**Other Accommodations**

- Housing-related requests
- Dining-related requests (e.g., food allergies)