



## Office of Accessibility Disability Documentation Form

**Student Name:** \_\_\_\_\_ **Student ID:** \_\_\_\_\_

**IMPORTANT:** The Americans with Disabilities Act (ADA) and the ADA Amendments Act of 2008 (ADAAA) define 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 the Office of Accessibility (OA) to determine eligibility for accommodations. Insufficient information may result in delays or ineligibility. **Complete one documentation form for each diagnosis or condition.** Please note the following information:

- Any record provided to OA 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.

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### To Be Completed by Diagnostician or Treating Professional

Date of birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ DSM-V or ICD code: \_\_\_\_\_

Date of diagnosis: \_\_\_\_\_ Date of most recent office visit: \_\_\_\_\_

Does this disorder substantially limit the student?  **Yes**       **No**

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

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

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

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Will medication adversely impact this student, if so how?

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Expected duration of the impact of the disability:

- Temporary - Indicate anticipated recovery date: \_\_\_\_\_
- Permanent
- Chronic
- Episodic/Recurring

Expected progression or stability of the impact of the disability:

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Recommended accommodations related to disability, including those used in the past:

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Name of Diagnostician/Professional: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

License #: \_\_\_\_\_

Organization: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Please attach a copy of your business card and submit the accompanying report to the counselor as requested by student/patient:**

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Rowan-Cabarrus Community College

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