



HEARTLAND  
COMMUNITY COLLEGE

Heartland Community College  
Disability Support Services  
**Disability Verification Form**

Revised 3/5/09

The student named below may be eligible for reasonable accommodations at this college. In order to provide services, we must have documentation of a disability that impairs one or more major life functions. This form can be submitted to Disability Support Services via fax at 309-268-7877 or mail at 1500 W. Raab Road, Normal, IL 61761.

**TO BE COMPLETED BY THE STUDENT:**

Student Name \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Email: \_\_\_\_\_

I hereby authorize the provider listed below to complete this form and provide information pertaining to my disability to Heartland Community College, Disability Support Services Office.

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

**TO BE COMPLETED BY A LICENSED PROFESSIONAL:**

Name of provider (print): \_\_\_\_\_ Phone number \_\_\_\_\_

This portion of the form is to be completed by a licensed professional qualified to make the diagnosis for which the student is seeking accommodations. It cannot be completed by a practicing family member of the student. Please provide the following information in full (please be specific). ***This form is not valid unless there is a diagnostic statement given, a description of the disability is provided, functional limitations are listed, and it is signed and dated in the appropriate place.***

**Diagnostic Statement:** \_\_\_\_\_

**Description of the disability:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For psychiatric disabilities, DSM IV-TR diagnosis or succeeding equivalent:  
\_\_\_\_\_

For learning disabilities/ADHD, describe the diagnostic methods that were used?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In what settings or on what academic tasks will this disability likely manifest itself? Circle all that apply.

Classes      Assignments      Communication      Testing      Time Constraints  
Attendance      Campus Mobility      Other: \_\_\_\_\_

**Functional Limitations** within an academic setting:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> limited ambulation                                     | <input type="checkbox"/> visual acuity  | <input type="checkbox"/> degree of hearing loss (_____) |
| <input type="checkbox"/> substantial difficulty processing auditory information | <input type="checkbox"/> substantial difficulty concentrating                 |   |
| <input type="checkbox"/> substantial difficulty memorizing information          | <input type="checkbox"/> substantial difficulty using hands                   |   |
| <input type="checkbox"/> substantial difficulty expressing self in writing      | <input type="checkbox"/> substantial difficulty processing visual information |   |
| <input type="checkbox"/> substantial difficulty performing math calculations    | <input type="checkbox"/> easily distracted                                    |   |
| <input type="checkbox"/> substantial difficulty with organizational skills      | <input type="checkbox"/> reading decoding                                     | <input type="checkbox"/> reading comprehension          |
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**Services and accommodations that you would recommend for this student:**

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> extended time on tests | <input type="checkbox"/> notetaker                               | <input type="checkbox"/> taped textbooks           | <input type="checkbox"/> use of a computer    |
| <input type="checkbox"/> tape recorder          | <input type="checkbox"/> reduced distraction testing environment | <input type="checkbox"/> sign language interpreter |   |
| <input type="checkbox"/> scribe                 | <input type="checkbox"/> reader                                  | <input type="checkbox"/> calculator                | <input type="checkbox"/> preferential seating |

Please list other accommodations you would recommend

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Prescribed medications, dosage, side effects

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The above mentioned disability (ies) is/are:

- Permanent/Chronic  
 Temporary:  less than 45 days  45 plus days

Severity is:  Mild  Moderate  Severe

I certify that all the information on this form is true and correct to the best of my knowledge.

Signature of Licensed Professional \_\_\_\_\_ Date \_\_\_\_\_  
Title or License Type and Number \_\_\_\_\_

If you have any questions, please feel free to contact Disability Support Services at 309-268-8259.