

Documentation Form

Medical Impairment or Chronic Medical Condition

This form is to be completed in its entirety by a qualified medical professional

Student's Name: _____ **OCC ID:** _____

The student named above is applying for disability accommodations and / or services through the Office of Disability Services ("Disability Services") at Ocean County College (OCC). To determine eligibility, a qualified professional must certify that the student has been diagnosed with a medical impairment or chronic medical condition and provided evidence that it represents a substantial impediment to a major life activity. It is important to understand that a diagnosis of a medical impairment or chronic medical condition in itself does not substantiate a disability. In other words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity.

This documentation form was developed as an alternative to traditional diagnostic reports. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the Disability Services website (go.ocean.edu/DS) in order to view documentation guidelines. Disability Services expects the following regarding this documentation form:

- The form will be completed with as much detail as possible as partially completed form or limited responses may hinder the eligibility process.
- The diagnosis of a medical impairment or chronic medical condition was derived through a formal assessment
- The assessment information is not more than three years old.
- The form is being completed by an appropriate, qualified medical professional familiar with the student's condition and history.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

Please respond to the following items regarding the student named above (type or print):

What is the student's diagnosis: _____

Date student was first diagnosed: _____

Date student was last seen: _____

Age of onset: _____

Date of first contact with student: _____ **Date of last contact with student:** _____

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What is the severity of the condition (check one): Mild Moderate Severe

Explain the severity indicated above: _____

What is the expected duration (check one): Chronic Episodic Short-term

Explain the duration indicated above: _____

Explain the student's prognosis regarding this condition: _____

Provide information regarding the student's current presenting concerns (be specific): _____

Provide information regarding the student's current symptoms: _____

Does the student have a disability* as a result of their condition that warrants accommodations (check one)? Yes No

**The ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity.*

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Is the student currently taking medication for the above-mentioned diagnosis (check one): Yes No

List the student's current medication(s), dosage, frequency, and adverse side effects (if applicable for the above-mentioned diagnosis): _____

Are there significant limitations to the student's functioning directly related to the prescribed medications? If yes, explain: _____

State the student's functional limitations from the disorder specifically in a classroom or educational setting (e.g., can the student remain seated for long periods, able to maintain focus, regularly attend class): _____

State specific recommendations regarding academic adjustments or accommodations, aids, and/or services for this student at the postsecondary level and the reasons these accommodations are recommended based upon the student's functional limitations: _____

If current treatments (e.g., medications) are successful, state the reasons the above academic adjustments or accommodations, auxiliary aids, and/or services are necessary: _____

Certifying Professional

All areas below must be completed by the certifying professional

Name and Title: _____

License or Certification #: _____

Company/Office/Institution/Affiliation Name: _____

Address: _____

City, State, Zip: _____

Phone #: _____ Fax #: _____

Email Address: _____

Signature of
Certifying Professional: _____ Date: _____

Official Company/Office/Institution/Affiliation Stamp or Business Card (stamp below)

Documentation Retention

All submitted materials will be held with OCC Disability Services as confidential educational records under the Family Educational Rights and Privacy Act (FERPA). Students have a right to review their educational record. However, students are encouraged to retain their own copies of disability documentation for future use as the college is not obligated to produce copies for students. Under current New Jersey record retention requirements, disability documentation is mandated to be held for only two years after a student has stopped attending the college.

Methods of return to OCC Disability Services:

- Print, scan and upload via the secure student Accommodate portal (online)
- Print, scan and upload to general office portal go.ocean.edu/upload
- Print and fax to 732-864-3860
- Print and scan to accommodations@ocean.edu

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