

# West Kentucky Community & Technical College disABILITY Services

## Documentation Verification Form

To help determine eligibility for accommodations, Disability Services requires complete disability documentation to help understand the limitations or barriers caused by a student's disability.

**Please note- This documentation verification form MUST be completed by a physician (doctor) certified in the disability area.**

Documentation pertaining to: \_\_\_\_\_ (Student Name)

**Step 1.** Read the definition below of a disability as defined by the Americans with Disabilities Act (ADA) as amended (Reference:

[http://www.ada.gov/regs2010/titleII\\_2010\\_regulations.htm#a35104](http://www.ada.gov/regs2010/titleII_2010_regulations.htm#a35104)).

*Disability* means, with respect to an individual, a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment.

The phrase *physical or mental impairment* means—Any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine; Any mental or psychological disorder such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.

The phrase *physical or mental impairment* includes, but is not limited to, such contagious and noncontagious diseases and conditions as orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional illness, specific learning disabilities, HIV disease (whether symptomatic or asymptomatic), tuberculosis, drug addiction, and alcoholism.

The phrase *major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

**Step 2.** State the medical or mental health impairment by a recognizable diagnosis; preferably from the most recent edition of *ICD* or *DSM*. Describe how you arrived at the diagnosis. Include as needed: background information, evaluation methods, tests and dates of administration, as well as a clinical narrative, observation and specific results. Attach additional documents if necessary.

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**Step 3.** Please check which of the major life activities listed below is affected because of the disability. Please indicate the level of limitation.

	No Impact	Moderate Impact	Substantial Impact	Don't Know
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing internal distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Managing external distractions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Organization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Timely completion of tests/assignments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress Management/ Coping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading ability and/or reading comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information processing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication *Written expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication *Verbal expression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math *Calculation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Math *Reasoning/Problem-Solving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Handwriting/Typing abilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please explain, in further detail, any item above rated as either **Moderate** or **Substantial** Impact, adding any additional information that will assist in providing appropriate and reasonable accommodations:

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**Step 4. Recommend accommodations** for the student to have equal access to its programs and services.  
*Please include current and past accommodations and services if known. (These are not prescriptive.)*

These are **SOME examples of accommodations** that Disability Services has provided in the past. **Since accommodations are decided on a case-by-case basis, this is not a complete list.** After a review of Documentation, reasonable accommodations will be decided upon by the Manager of Disability Services with input from the student. (Please print or type)

- testing in a distraction-reduced environment
- extended time (time & a half) on exams & quizzes
- permission to audio record lectures or use Smartpen

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**Step 5.** By signing below, you as physician are verifying that the disability or condition that was described above meets the ADA definition of a disability that substantially limits a major life activity.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Physician's Name: \_\_\_\_\_

Professional Medical Title: \_\_\_\_\_

State License and Number: \_\_\_\_\_

Address (complete): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

For more information and assistance on Disability Services, please contact Shelia Highfil, Manager of Disability Services at (270) 534-3406, fax (270) 554-6203 [shelia.highfil@kctcs.edu](mailto:shelia.highfil@kctcs.edu).