KANKAKEE COMMUNITY COLLEGE
Office Of Disability Services
Reasonable Accommodation Verification Form

Kankakee Community College (KCC) is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide reasonable accommodations, in the form of academic adjustments and auxiliary aids and services, for qualified students with documented disabilities. The purpose of reasonable accommodations is to provide equitable access to all aspects of the college's programs. The outline below has been developed to assist the student in working with the treatment or diagnosing healthcare professional (psychiatrist, psychologist, counselor, social worker, medical doctor, optometrist, speech-language pathologist, etc.) in obtaining the specific information to evaluate eligibility for reasonable accommodations in the higher education setting.

KCC's Office of Disability Services (ODS) endeavors to provide reasonable accommodations for qualified students with documented disabilities. ODS does not modify essential elements of an instructional program or course or provide accommodations for students whose impairments do not substantially limit one or more major life activities. This form is designed to allow ODS to achieve these goals. The healthcare provider need not use this specific form, but all the information requested here is necessary to consider the request; the form is provided as a convenience.

Please take note of the following as you complete the form:

A. The person completing this form should be a qualified medical professional who is (1) qualified to assess and diagnose the student's condition, and/or (2) was a part of the student's treatment plan for a previously diagnosed condition.

B. **Please complete all parts of this form legibly and as thoroughly as possible.** Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow-up contact for clarification. This PDF provides fillable form fields to allow for typed answers. Typed answers are highly recommended.

C. The healthcare provider or student should attach any documents which provide additional related information. (e.g., psychoeducational assessment, neuropsychological test results, an Individualized Education Program (IEP), Multifactor Evaluation (MFE), Evaluation Team Report (ETR), a 504 plan, verification of accommodations provided by another college/university or third-party entity, etc.) **If a comprehensive diagnostic report is available that provides the requested information, copies of the report can be submitted for documentation in place of this form. In addition to the requested information, please attach any other information that would be** relevant to the student's need for accommodations.

For questions regarding this form, please contact
Office of Disability Services via email at
disabilityservices@kcc.edu

I. STUDENT INFORMATION (to be completed by the student)

Student Name (first/last): ______________________ Date of Birth: ______________________

KCC Student ID Number: ______________________

KCC email address ______________________ Personal email address ______________________

STUDENT (please sign below before providing it to your healthcare provider to complete): By signing below, I consent to allow my healthcare provider to share any information relevant to my need for a reasonable accommodation with the Office of Disability Services at Kankakee Community College for the next 60 days.

Student Signature ______________________ Date: ______________________

II. MEDICAL INORMATION (to be completed by the Certifying Physician or Medical Professional)
Federal law defines a disability as "a physical or mental impairment that substantially limits one or more major life activities." Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that any diagnosed condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to "substantially limit" one or more major life activities.

I, the undersigned diagnostic/treating professional, certify that the above-named student: (**Check One**)

☐ Has a medical condition that impacts them but does not rise to the level of a disability (if selected, sign the last page of the document)

☐ Does not have a condition that would require the requested modification(s) (if selected, sign the last page of the document)

☐ Meets the definition of a disability as defined by the Americans with Disabilities Act & Section 504 of the Rehabilitation Act of 1973 (if selected please complete the information below

Diagnosis: **Secondary Impairment:**

Initial Date of Diagnosis: **Most Recent Appointment:**

Is the student in treatment with you for their disability? ☐ Yes ☐ No

What is level of the student’s disability? ☐ Stable ☐ Variable ☐ Progressive

Severity of current symptoms: ☐ Mild ☐ Moderate ☐ Severe

Describe the symptoms that meet the criteria for this diagnosis:

Current side effects from medications that are impacting the student:

How frequently does this student experience the above effects to medication?

☐ Rarely ☐ Occasionally ☐ Frequently

Is follow up treatment required or recommended? ☐ No ☐ If yes, when or how often?

Is the student compliant with their treatment plan to minimize the impact of their condition?

☐ Yes ☐ No

Duration of the impairment is: ☐ Permanent

☐ Temporary-Provide expected duration OR re-evaluation date

How was the diagnosis determined? Check all that apply. Please submit all diagnostic reports and/or evaluations.

☐ Structured interview ☐ Unstructured interview

☐ Medical history ☐ Educational history

☐ Behavioral observation ☐ Interviews with other persons

☐ Other: Please describe

Neuropsychological testing (including the report will assist in determining supporting accommodations) Psychoeducational testing (including the report will assist in determining supporting accommodations)

Other:

Major Life Activities Assessment: Please check each of the following major life activities that are impacted by the disability. Indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Uncertain	Life Activity	Negligible	Moderate	Substantial	Uncertain
Attending class	☐	☐	☐	☐	Memorization	☐	☐	☐	☐
Breathing	☐	☐	☐	☐	Organization	☐	☐	☐	☐
Calculating	☐	☐	☐	☐	Pain management	☐	☐	☐	☐
Caring for self	☐	☐	☐	☐	Performing manual tasks	☐	☐	☐	☐
Concentration	☐	☐	☐	☐	Remembering	☐	☐	☐	☐
Driving	☐	☐	☐	☐	Seeing	☐	☐	☐	☐

Life Activity	Negligible	Moderate	Substantial	Uncertain	Life Activity	Negligible	Moderate	Substantial	Uncertain
Eating or diet	☐	☐	☐	☐	Sitting	☐	☐	☐	☐
Elimination of bodily waste	☐	☐	☐	☐	Standing/Walking	☐	☐	☐	☐
Hearing	☐	☐	☐	☐	Sleeping	☐	☐	☐	☐
Interacting with others	☐	☐	☐	☐	Speaking	☐	☐	☐	☐
Learning	☐	☐	☐	☐	Thinking	☐	☐	☐	☐
Lifting or bending	☐	☐	☐	☐	Spelling	☐	☐	☐	☐
Managing internal/external distractions	☐	☐	☐	☐	Writing	☐	☐	☐	☐

Major Bodily Function Assessment: Please check each of the following major bodily functions that are impacted by the disability. Indicate severity of limitations.

Life Activity	Negligible	Moderate	Substantial	Uncertain	Life Activity	Negligible	Moderate	Substantial	Uncertain
Bladder	☐	☐	☐	☐	Immune system	☐	☐	☐	☐
Brain	☐	☐	☐	☐	Neurological	☐	☐	☐	☐
Bowel	☐	☐	☐	☐	Normal cell growth	☐	☐	☐	☐
Circulatory	☐	☐	☐	☐	Respiratory	☐	☐	☐	☐
Digestive	☐	☐	☐	☐	Reproductive	☐	☐	☐	☐
Endocrine	☐	☐	☐	☐					

III. RECOMMENDED ACCOMMODATIONS (to be completed by the Certifying Physician or Medical Professional)
Recommended accommodations will be considered but are not automatically included as part of a student's reasonable accommodations at Kankakee Community College.

What accommodations are recommended to mitigate or eliminate the impact of the disability on the student's academic life? Accommodations are provided on a case-by-case basis and are not limited to the list below.

- ☐ No accommodations are required
- ☐ Extended time on exams & quizzes (50%)
- ☐ Extended time on exams & quizzes ________%
- ☐ Distraction reduced testing area
- ☐ Test reader
- ☐ Test scribe
- ☐ Use of computer (class and or testing)
- ☐ Enlarged font
- ☐ FM system
- ☐ ASL interpreter
- ☐ Closed captioning
- ☐ Communication Access Realtime Translation (CART)
- ☐ Accessible furniture
- ☐ Excused medical absences
- ☐ Readings in alternative formats
- ☐ Recording of lectures
- ☐ Notetaker
- ☐ Assistive technology (identify)
- ☐ Other (list)

Please explain the rationale for each accommodation, including a detailed explanation of its relevance to the diagnosed disability and how it will mitigate the symptoms/impact of the disability on the student's academic experience.

List alternative to meet the documented need if the above accommodations cannot be met.

Discuss the potential impact on your client if the recommended accommodation(s) cannot be granted.

Final determination of appropriate accommodations will be determined by the Office of Disability Services after a meeting is conducted with the student and, faculty or other disability service professionals as necessary in accordance with the mandates of the Rehabilitation Act of 1973 and the Americans with Disabilities Act as well as court rulings and Department of Education Office of Civil Rights rulings related to these two laws.

The information provided is used in determination of reasonable accommodations at Kankakee Community College. This information is kept confidential within the Accessibility and Disability Resources office and will not become part of a student's educational record. This document may not be released without written permission from the student or in accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA).

I certify, by my signature below, that this information is true, accurate, and complete; and I am not related to nor have a relationship with this student outside of the provider/client relationship.

Provider Signature: Date:

Printed Name and Title:

State or License: Type of License: License Number:

Address:

Phone: Fax:

Thank you for taking the time to complete this form. If we need additional information, we may contact you later. The named student has signed this form (above) indicating written permission to share additional information with us in support of the request.

Please return the completed form to:
Kankakee Community College, Office of Disability Services
100 College Dr Kankakee IL 60901
Questions? Reach us by phone: 815-802-8632