CALHOUN
COMMUNITY COLLEGE

Please Return Form To:

STUDENT DISABILITY SERVICES/ADA
P.O. Box 2216 | Decatur, AL 35609
(256) 306-2630 | Fax: (256) 260-2447

Impairment and Disability Assessment

******TO BE COMPLETED BY A DOCTOR, LICENSED COUNSELOR, OR MEDICAL PROFESSIONAL******

In order for Calhoun Community College to provide disability-related services, we need to establish this student has a qualifying disability. A disability is defined as an impairment substantially limiting a major life activity. This form is designed to help us make that assessment. Please respond to the following items:

Student Name: ______________________________ Date of Birth: ____________________

Name of Doctor/Licensed Counselor/Medical Professional: ______________________________

Facility Name and Address: ______________________________

____

Phone: ______________________________ Date: ____________________

Signature of Medical Professional ______________________________

I. Impairment Assessment

A. What is the diagnosis/impairment?

____

A. When was the diagnosis originally made?

____

A. Is the patient/student currently under your care?

____

A. When did you last see the patient/student?

____

A. Is the impairment temporary (<6 months) or persistent?

____

(Continued on back)

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II. Major Life Activities Assessment

Please check any of the major life activities listed below that are affected as a result of the impairment.
Please indicate the level of limitation.

1 – Negligible 2 – Moderate 3 – Substantial

	1	2	3
Caring for oneself			
Speaking			
Hearing			
Breathing			
Standing			
Working			
Eating			
Lifting			
Walking			
Seeing			

	1	2	3
Bending			
Performing manual tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Communicating with others			
Other:			
Other:			

What are the functional limitations resulting from the impairment's impact on major life activities identified in the assessment above?

___

___

___

Based upon the major life activities affected by the impairment, are there any accomodations within the context of the community college environment that you can recommend for this student?

___

___

___

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STUDENT WITH A DISABILITY:

Individual Postsecondary Plan

Student Name: ______________________ ID #: ________________________ Date of Birth: _______________

Mailing Address: ____

Phone: ____ Email: ___________________________

Please describe your disability and include a list of necessary medication(s):

____

____

Did you receive accommodations at a previous high school or college? ( ) YES ( ) NO

If you answered "YES", then where? ____

What type of accommodations did you receive?

____

____

What type of academic adjustments and modifications would you like to receive?

____

____

Do you wish to have your clinical/field experience instructors notified by the Student Disability Services/ADA Office that reasonable accommodations are requested? ( ) YES ( ) NO

Student Signature: ____ Date: ____________________

CONFIDENTIAL

Student Disability Services/ADA
PO Box 2216, Decatur, AL 35609
Phone 256-306-2630 ● Fax 256-260-2447

Request for Academic Adjustments and Modifications

Name: ________________________________ **Student ID#:** _______________ **Date of birth:** _________

Phone Number: ___________________________ **Calhoun email:** _________________________________

1. **Select ONE term**: Fall _____ Spring _____ Summer _____
2. **Select appropriate request**:

   _____ First time requesting academic adjustments and modifications

   _____ Request the same academic adjustments and modifications as previous term

   _____ Request to meet with Student Disability Services/ADA staff to discuss different academic adjustments and modifications

3. **Your ADA letter will be emailed to your Calhoun email address.**
4. **Select one of the options below:**

______ I authorize the Student Disabilities Services/ADA office to provide my ADA letter to my classroom and clinical/field experience instructor(s).

_____ I do not authorize the Student Disabilities Services/ADA office to provide my ADA letter to my classroom and clinical/field experience instructor(s).

5. **I authorize the Student Disability Services/ADA office to discuss/release information to the following people (Please print full names & relationships).**

____

6. **I authorize the Student Disability Services/ADA office to discuss/release information to:**
   ___ Testing Center ___ STAR Institute ___ Math Lab ___ Writing Lab
7. **Your instructor will contact you regarding the use of academic adjustments in your course. If your instructor does not contact you within five (5) days of receipt of your letter, please notify the Student Disability Services/ADA Office.**
8. **If you review your ADA letter with your instructor(s), ask each instructor to return an acknowledgement receipt.**

Student Signature _____________________________________ Date _________________________

It is the policy of the Alabama Community College System and Calhoun Community College, a postsecondary institution under its control, that no person shall, on the grounds of race, color, disability, sex, religion, creed, national origin, or age, be excluded from participation in, be denied benefit of, or be subjected to discrimination under any program, activity, or employment.