



Disability Support Services at Schoolcraft College provides services to students with disabilities. The student named below may be eligible for services offered through this office. The purpose of this form is to ensure our office has record of a student’s relevant disability information that may aid in the exploration of the reasonable accommodations.

Information shared with this office is confidential. All records are stored in the Disability Support Services Office at Schoolcraft College and are not part of the student’s academic record.

Completed by student:

Student Name: _____

SC Student Number: _____ Date of Birth: _____

I authorize the release of the information requested to Disability Support Services at Schoolcraft College

 Signature

 Date

Completed by licensed medical professional:

This section is to be completed by a fully licensed health care professional who has first-hand knowledge of the student’s disability, such as the treating or diagnosing physician, psychiatrist, psychologist, social worker, counselor, therapist or other qualified medical professional who is licensed to diagnose. **If the patient has multiple diagnoses, please complete an additional form to ensure an accurate record of their disabilities.**

1. Primary Diagnosis: _____

DSM/ICD Code: _____ Level of severity: Mild Moderate Severe

Date of diagnosis: _____ Is this a permanent disability: Yes No

2. Secondary Diagnosis: _____

DSM/ICD Code: _____ Level of severity: Mild Moderate Severe

Date of diagnosis: _____ Is this a permanent disability: Yes No

3. Date of last office visit: _____

4. Medication prescribed: _____

Implications for Educational Success:

5. Assessments or evaluation tools used to diagnose. Please attach report, if available. (MMPI-2, BAI, BDI-II, ASRS, Wechsler, diagnostic interview): _____

6. Functional limitations on learning abilities in higher education environment (processing, concentrating, memory, managing distractions, etc.): _____

7. Functional limitations on exams and classroom activities in higher education environment (test taking, note taking, etc): _____

8. Please list specific accommodations or services to address the functional limitations identified:

I certify that the above referenced patient/client has a “physical or mental impairment that substantially limits one or more of the major life activities of such an individual” as defined by the Americans with Disabilities Act. In addition, I have the necessary professional qualifications to document my patient/client’s disability and the information provided on this form is accurate to the best of my ability.

Name of Professional (Please print): _____

Signature of Professional: _____

License #: _____

Date: _____

Address: _____

Phone: _____

Fax: _____



New Students:
Please submit your documentation by scanning the QR code with your phone’s camera or going to schoolcraft-accommodate.symphonicity.com/public_accommodation

