STDV-06

Rappahannock Community College
Disability Assessment Form

_____

(Student Name) **(Date Of Birth MMDDYYYY)** **(Emplid)**

TO BE COMPLETED BY THE STUDENT:

I authorize _____
(Name of Health-Care Professional)

Clinic Name: _____

Clinic Address: _____
(Street Address)

_____
(City, State and Zip)

Clinic Phone: _____ **Clinic Fax:** _____

to release information pertaining to the diagnosis and treatment of _____
(Name of disability)

to the counseling department at Rappahannock Community College.

_____

(Student Signature) **(Date)**

Dear Health Care Provider: The above-named student has requested accommodations for one or more disabilities while enrolled at Rappahannock Community College. Prior to providing disability-related services, appropriate documentation verifying the student's disability/impairment and current level of functioning must be received and reviewed by one of our trained professionals. Thank you for providing this information in a timely manner.

Health Care Provider Name: _____

Health Care Provider Address: _____
(Street Address)

_____
(City, State and Zip)

Phone: _____ **Fax:** _____

1. Impairment Assessment

A. What is the diagnosis/impairment? _____

B. When was the diagnosis originally made? _____

C. Is the patient/student currently under your care? _____

D. When did you last see the patient/student? _____

E. Is the impairment temporary (< 6mth) or persistent? _____

If applicable, please list Axis diagnosis by name:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V GAF _____

Current list of prescribed medications: _____

_____

Possible negative side effects medications may have on learning (e.g., slowed processing speed, distractibility): _____

_____

_____

2. Professional Assessment of Impact of Disability on Major Life Activities

Please rate any of the major life activities listed below that might be affected as a result of the student's disability/impairment.

LEVEL OF LIMITATION

FUNCTION	NEGLIGIBLE 1	MODERATE 2	SUBSTANTIAL 3	COMMENTS
Caring for oneself				
Performing manual tasks				
Walking				
Seeing				
Hearing				
Speaking				
Breathing				
Learning				
Thinking				
Sitting				
Standing				
Reaching				
Interacting with others				
Concentrating				
Lifting				
Sleeping				

Describe the functional limitations resulting from the impairment's impact on major life activities identified in #2 above?: _____

Please list any accommodations that would help the student compensate for the aforementioned disability within the context of the college environment (i.e. extended time on tests, tape record classes): _____

Other pertinent information: _____

(Health Care Professional Signature) **(Date)**

THIS FORM MAY BE RETURNED BY MAIL, FAX, OR AS AN EMAIL ATTACHMENT.

Fax Number: **Glenns Campus Admissions 855-575-5207** **Warsaw Campus Admissions 855-575-5207**

Mailing address: **RCC Glenns Campus Counseling, 12745 College Drive, Glenns VA 23149**
RCC Warsaw Campus Counseling, 52 Campus Drive, Warsaw VA 22572