

## **Disability Certification Packet**

Dear Health Care Professional:

SUNY Schenectady County Community College offers individualized accommodations and services to students with documented disabilities. Please certify the disability diagnosis of the student named on the following page by responding to the questions in this disability certification packet.

The details you provide in your responses are crucial for not only documenting the student's disability, but also for helping the student and I work together to determine ways that make classes accessible. Please send the completed packet to the address appearing at the top right of this page.

Feel free to contact me with any questions. Thanks for your response.

Sincerely,

Susanna Adams  
Coordinator, ADA Transition Services

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## Disability Certification Packet

**FOR STUDENT TO COMPLETE (please print):**

Student Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

I, \_\_\_\_\_, give \_\_\_\_\_ permission to  
Student Name Name of Health Care Professional

exchange information about my disability with the Office of ADA Transition Services at SUNY Schenectady.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

## FOR HEALTH CARE PROFESSIONAL TO COMPLETE<sup>1</sup> (please print or type):

**1. Diagnostic Statement:**

Current Diagnosis/Diagnoses:

**2. Basis of Diagnosis:**

Please provide a brief description of the diagnostic methodology you used, including date(s) of diagnostic tests and procedures, diagnostic criteria, clinical narrative, and where appropriate, specific test scores with norming population as well as summary data. Nonstandardized evaluations should be described in sufficient detail for a professional colleague to understand. If psychological tests were administered, please attach a copy of the report.

**3. *Impact of Disability:***

**(a) How does the disability impact the individual's current physical, cognitive, and social-emotional functioning?**

**(b) What impact does the disability have on fulfilling college demands?**

**4. *Expected Progression/Stability of Disability:***

**(a) What is the expected progression and/or stability of the disability?**

**(b) Do disability symptoms have any suspected triggers? If so, please describe the triggers along with appropriate interventions for the college setting.**

**5. *Treatment/Services/Assistive Devices:***

**(a) What accommodations, services, assistive devices and/or medications is the individual currently using and what has been used in the past?**

**(b) If the individual is taking medication, please describe the how the side effects are likely to impact his or her functioning in the educational setting.**

**6. *Recommended Accommodations:***

**What are your recommendations for accommodations, assistive devices, assistive services, compensatory strategies, and/or collateral support services? Please explain the relationship between the accommodations that you recommend and the symptoms of the diagnosed disability/disabilities.**

**7. *Health Care Professional Information (please print):***

**Name and Title of Health Care Professional:** \_\_\_\_\_

**Credential/Certification:** \_\_\_\_\_

**State Licensure Number (if applicable):** \_\_\_\_\_

**Name of Practice:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Signature of Health Care Professional:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<sup>1</sup>Questions are based on the Association of Higher Education and Disability guidelines.  
<http://www.ahead.org/resources/best-practices-resources/elements>