Cleveland Institute of Art

GUIDELINES FOR DOCUMENTATION OF DISABILITIES

Students with disabilities requesting services from the Accessibility & Disability Support Services Office must furnish documentation that meets the criteria set forth by the ADA and Section 504 guidelines.

I. For a **learning disability**, this documentation may be in the form of an existing Individualized Education (IEP) from high school identifying the student as being served for a specific learning disability

AND/OR a multi-factored psychoeducational evaluation completed by a psychologist or a school psychologist during grades 10, 11, or 12.

Both are preferable.

If neither of these is available, students should have their medical professional complete the attached Disability Verification Form.

II. For a **physical or psychological disability**, documentation should include:

- Credentials of the licensed professional providing the diagnosis (who has no personal relationship with the individual being evaluated);
- An explanation of the current manifestations or functional limitations of the disability;
- A description of current and past accommodations, services and/or medications and their effects; and
- Recommendations for accommodations or support services that relate directly to the current functional impact of the disability.

OR Students can have their medical professional complete the attached Disability Verification Form.

Please send documentation to: Wellness and Accessibility Services, via confidential fax (216) 238-6158; email: disabilityservices@cia.edu; or U.S. mail to Cleveland Institute of Art, 11610 Euclid Blvd., Cleveland, OH 44106.

Cleveland Institute of Art

DISABILITY VERIFICATION FORM

Accessibility & Disability Services
Cleveland Institute of Art
11610 Euclid Avenue
Cleveland, OH 44106
Phone: (216) 421-7463
Confidential fax: (216) 238-6158
disabilityservices@cia.edu

Students with disabilities requesting services from the Accessibility & Disability Support Services Office must furnish documentation that meets the criteria set forth by the ADA and Section 504 guidelines. Students must contact a qualified professional to arrange to have copies of one of the following submitted to the Learning Support Services Office. Depending on the nature of a student's disability, qualified professionals could include a medical doctor, psychiatrist, psychologist, or other healthcare provider. All documentation must be current and relevant.

Documentation can be submitted in one of two ways:

1. Completion of the attached form, **OR**:
2. **If a comprehensive diagnostic report can provide the requested information, that report can be submitted for documentation instead of this form.**

The healthcare provider should attach any reports which provide additional related information. After completing this form, sign it, complete the healthcare provider information section on the last page, and mail or fax it to us at the address provided above. The information will be kept in the student's file in the Accessibility & Disability Support Services office where it will be held in strictest confidence.

Cleveland Institute of Art

Disability Verification Form

Student Information

First Name: _____ Middle: _____ Last: _____

Date of Birth: _____

Local Phone (___) _____-_____ Cell Phone (___) _____-_____

Address (street, city, state and zip code):_____

_____

Diagnostic Information

1. Date of Diagnosis:_____

2. Primary Diagnosis: _____
   Secondary Diagnosis: _____
   Any other diagnoses: _____

3. Date of first contact with student:_____
   Date of last contact with student: _____

4. Please describe the student's disability:
   _____
   _____
   _____

5. Describe the symptoms associated with this condition:
   _____
   _____
   _____

6. What is the expected duration of this disability?
   _____
   _____

7. What is the severity of the condition? Please check one:

____ Mild ___ Moderate ____ Severe

Explain severity: _____

_____

8. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful.
    - o Medical evaluation (x-ray, lab work, EKG, etc.)
    - o Structured or unstructured interviews with student.
    - o Interviews with other persons (i.e. parent, teacher, therapist).
    - o Behavioral observations.
    - o Neuropsychological testing. Attach documentation.
    - o Psychoeducational testing. Attach documentation.
    - o Other (Please specify). _____

    Notes: _____

    _____

9. List the current medication(s), dosages, frequency, and possible adverse side effects as related to academic performance:

    _____

    _____

    _____

10. List any other treatment that the student is receiving to manage his/her condition:

    _____

    _____

    _____

11. Describe the effect of the diagnosis on academic performance and attendance. Please include specific symptoms that might affect his/her academic performance:

    _____

    _____

    _____

    _____

12. Describe the effect of the diagnosis on campus housing, dining, and other student life events. Please include specific symptoms that might affect these areas:

    _____

    _____

    _____

    _____

Please provide information about how the disorder(s) may affect the student with respect to various life activities:

Life Activity	No Impact	Mild Impact	Moderate Impact*	Severe Impact*	Don't Know
Seeing					
Hearing					
Speaking					
Sitting					
Standing					
Walking					
Breathing					
Eating					
Sleeping					
Lifting					
Performing manual tasks					
Performing self-care tasks					
Learning					
Thinking					
Concentrating					
Managing external distractions					
Managing internal distractions					

*Please elaborate on moderate and severe impacts: _____

_____

_____

_____

_____

_____

Please provide information about how the disorder(s) may affect the student with respect to various life activities:

Life Activity	No Impact	Mild Impact	Moderate Impact*	Severe Impact*	Don't Know
Initiating to work (activating)					
Sustaining focus					
Remembering (memorizing)					
Managing stress					
Making/keeping appointments					
Submitting assignments in a timely manner					
Sensory functioning/integrating					
Attending class (regularly/on time)					
Understanding directions					
Communicating					
Social interactions					
Writing (manual writing)					
Writing (written expression)					
Reading (visually)					
Reading (comprehension)					

*Please elaborate on moderate and severe impacts: _____

_____

_____

_____

_____

_____

Permission to use chart granted from The College of Wooster

13. Describe the effect of the diagnosis on independent living. Please include specific symptoms that might affect living independently:

    _____

    _____

14. Please state specific recommendations regarding academic accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

15. Please state specific recommendations regarding campus housing, dining, and other student life events accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

16. Please state specific recommendations regarding independent living accommodations for this student, and a rationale as to why these accommodations, adjustments, or services are warranted based upon the student's functional limitations. Indicate why the accommodations are necessary.

17. Please list any potential emergencies and steps to resolve the potential emergency that may arise from the medical condition:

18. Please provide any additional information you feel will be useful in determining the nature and severity of the student's disability, and any additional recommendations that may assist in determining appropriate accommodations and interventions.

_____
_____
_____
_____
_____

Healthcare Provider Information

Please sign and date below and fill in all other fields completely.

Provider's name (print):_____

Provider's signature: _____

Date: _____

Title: _____

License or Certification #:_____

Address: _____

_____

_____

Phone number (___) ____-_____ Fax number: (___) ____-_____