

**HARFORD COMMUNITY COLLEGE
CERTIFICATION OF HEARING IMPAIRMENT**

The student named below has applied for services from Harford Community College's Disability Support Services Office. In order to be able to determine eligibility and what, if any accommodations are warranted, documentation or additional documentation is needed.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability limits one or more major life activities (e.g. learning). *A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations.* The documentation must also support the request for accommodations and explain how the disability impacts learning.

Please complete the form and return by mail or fax to:

Harford Community College
Disability Support Services
401 Thomas Run Road
Bel Air, Maryland 21015
Attn: _____
Fax: 443.412.2200

Date: _____

Clinician's Name: _____ Credentials: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Signature: _____

Professionals conducting the assessment and rendering a diagnosis must be qualified to do so (e.g. a licensed physician). The provider signing this form must be the same person answering the questions on the form below.

Please note: it is NOT appropriate for professionals to evaluate members of their family or others with whom they have personal or business relationships.

Name of Student: _____ Date of Birth: _____

I, _____, authorize a release of information, allowing the Disability Support Services Office at Harford Community College to contact the physician completing this form to obtain additional information or clarification in order to determine reasonable accommodations.

Signature

Date

DIAGNOSIS:

Date of Diagnosis: _____

Date Last Seen: _____

- Deaf
- Hard of Hearing

Please describe: _____

CLINICAL DESCRIPTION OF DIAGNOSIS: *Please check all relevant symptoms and add additional symptoms not listed here in the space provided below.*

SEVERITY:

- Mild
- Moderate
- Severe

Please explain the severity of the condition below:

DURATION:

- Chronic
- Episodic
- Short-term

Please explain the duration of condition below:

PROGNOSIS:

- Stable
- Declining

If the condition is expected to decline, please describe the expected progression of the hearing loss:

AUDIOLOGICAL ASSESSMENT:

Please attach a copy of the most current assessment.

Date of Last Audiological Assessment: _____

Findings: _____

ADDITIONAL ASSESSMENT PROCEDURES:

Please list any additional assessment procedures or tests below. Be sure to include dates of administration, as well as clinical narrative, observations, and specific test results. Please attach any collateral information to this form.

DEVELOPMENTAL HISTORY:

Please provide pertinent developmental information obtained from the student or guardian(s).

FAMILY HISTORY:

Please provide pertinent information regarding the family's medical history.

MEDICAL HISTORY:

Please provide pertinent medical information, including any medical evaluations that rule out medical causes of the current symptoms.

PSYCHOSOCIAL HISTORY:

Please provide pertinent psychosocial information, if applicable.

SYMPTOMS:

Please provide information regarding specific symptoms the student may be experiencing and how they affect the student in an educational setting.

MEDICATION

CURRENT MEDICATIONS

Please provide information of current medications, including dosage and frequency:

Please explain what symptoms are alleviated by medication and what symptoms still exist:

Please list side effects from current medication:

How do these side effects affect the student in an educational setting (e.g. difficulty focusing, difficulty remembering, etc.):

What medication changes (including dosage changes have there been in the last six months:

IMPACT ON MAJOR LIFE ACTIVITIES

Please provide information regarding the impact, if any, the disorder has on specific major life activities (e.g. learning, hearing, walking, interpersonal, etc.).

Please check to indicate if the student requires the use of a service animal? Yes No

If yes, what essential function/s does the animal perform that the student cannot perform for his/herself?

ACCOMMODATIONS

Does the student use any of the following? Check to indicate and please specify type.

- Sign Language Interpreter
- FM System
- Hearing Aid
- Real-Time Captioning
 - CART
 - C-PRINT
 - Typewell

Please make recommendations for accommodations in an educational setting (e.g. use of interpreter, real-time captioning, hearing aids, microphone, etc.) and **indicate the reason these accommodations are warranted if the current treatments are successful.** Specify how the accommodations and strategies directly relate to symptoms and/or functional limitations.
