

Disability Documentation Guidelines

Students must provide documentation of disability to ensure the provision of reasonable and appropriate accommodations. Once you have completed the DRC New Student Application, review the options below for information on acceptable documentation. Documentation can be uploaded through the link provided in the application confirmation email, dropped off, emailed, or mailed to DRC offices.

- **Option 1 – IEP/504 Plan:** Provide all pages of your most recent IEP/504 plan from school, including any supporting documentation if available.
- **Option 2 – Supporting Documentation:** Provide a letter or medical records from a licensed professional containing the following information:
 - **A diagnostic statement identifying the condition (diagnostic code), date of the current evaluation and the date of the original diagnosis:** DSM-V or ICD Diagnosis (test and code), given based on a formal assessment of a disabling condition provided by a licensed professional (e.g. medical professional, psychiatrist, licensed psychologist, licensed social worker).
 - **A description of the current functional impact of the disability:** Include history of the disability, the expected progression or stability of the disability over time, and how the disability may impact a student's academic performance.
 - **Treatments, medications, assistive devices/services currently prescribed or in use:** Include an estimated effectiveness in improving the impact of the disability.
 - **The credentials of the diagnosing professional(s):** Certification, licensure and/or the professional training of the treatment provider.
- **Option 3 - DRC Documentation Verification Form (Attached)**
 - **Complete the first section of the form and give the form to your provider for completion:** licensed professional (e.g. medical professional, psychiatrist, licensed psychologist, licensed social worker).



DISABILITY RESOURCE CENTER
 5840 26th St., W., Bldg. 1, Rm. 219, Bradenton, FL 34207 • 941-752-5295
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 email: drc@SCF.edu

Documentation Verification Form

The Disability Resource Center (DRC) at State College of Florida provides accommodations and services for students with disabilities with the intent to help facilitate equal access to educational opportunities. This form must be completed by a licensed professional qualified to diagnose and treat the condition (e.g. medical professional, psychiatrist, licensed psychologist, licensed social worker).

Student Authorization Section

I _____ authorize _____ to complete and provide a
 (Print Student Name) (Print Provider Name)
 copy of this form to the State College of Florida Disability Resource Center (DRC).

Student Signature: _____ Date of Birth: _____ Date: _____

Healthcare Provider Section

The following information is to be completed and signed by the provider.

Date of first contact with your office: _____

How often is the patient seen? _____

Date of last contact: _____

Please fill in the information below about diagnosis(es):

Date of Diagnosis	Diagnosis	DSM-V or ICD codes	Anticipated Duration of Diagnosis
			<input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than a year
			<input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than a year
			<input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than a year
			<input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than a year
			<input type="checkbox"/> 3-6 Months <input type="checkbox"/> 6-12 Months <input type="checkbox"/> More than a year

Check off all sources used to verify diagnosis:

<input type="checkbox"/>	Psychological testing	<input type="checkbox"/>	Family History
<input type="checkbox"/>	Neuropsychological testing	<input type="checkbox"/>	Medical evaluation
<input type="checkbox"/>	Psychoeducational testing	<input type="checkbox"/>	Diagnostic (x-ray, lab work, MRI, etc.)
<input type="checkbox"/>	Structured or unstructured interview	<input type="checkbox"/>	Medical history supporting current presentation of symptoms.
<input type="checkbox"/>	Behavioral observations	<input type="checkbox"/>	Other: _____ _____ _____ _____
<input type="checkbox"/>	Academic history Individualized Education Plan (IEP), 504 Plan, teacher reports, etc.		

Current Treatment:

- Medication Management: List any side effects that may impact academic performance:

- Outpatient counseling/therapy - Number of visits per month: _____
- Physical/Occupational Therapy - Number of visits per month: _____
- Speech Therapy – Number of visits per month: _____
- Other (please describe) _____

Explain how the student’s disability impacts performance in a classroom setting? (e.g. Speaking, Note Taking, Concentration, Processing Speed)

Explain how the student’s disability impacts performance on timed tests? (e.g. Levels of Anxiety/Stress, Memory, Concentration, Processing Speed)

If applicable, explain how the student’s disability might impacts their ability to speak in front of a class. (e.g. class participation, public speaking)

Please provide any additional information you feel will be useful in determining appropriate accommodations and services:

Complete ONLY when chronic health conditions impact attendance and/or course deadlines:

- How often do medical episodes occur and how long do the symptoms last?

- Describe the impact of the symptoms:

- Date of last known episode: _____
- Does the episode/condition require hospitalizations (Y or N)? If yes, typical duration:

- Does the condition require regular treatments such as infusions, radiation (Y or N)? If yes, describe the side effects.

- Any upcoming surgeries related to the condition (Y or N)? If yes, date and expected recovery time?

Healthcare Provider Information

I certify by my signature that all information in this document is accurate and the patient is under my care.

Signature: _____ Date: _____

Print Name: _____ Print Title: _____

State of License: _____ License Number: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

It is preferred that this completed document is returned directly to the requesting student.

Alternatively, it can be submitted to the Disability Resource Center (DRC) via email to

DRC@SCF.edu or mailed to:

Disability Resource Center, State College of Florida
5840 26th Street West
Bradenton, FL 34207