CHRONIC HEALTH DISABILITIES VERIFICATION FORM

Special Services at Macomb Community College provides accommodations and services to students with chronic health disabilities. To determine eligibility, this office requires current and comprehensive documentation of the disorder or disability from the diagnosing physician, psychiatrist, fully-licensed psychologist, social worker or licensed professional counselor.

Information shared with this office is confidential. All records are housed in the Special Services Office at Macomb Community College and are not part of the student's academic record.

To ensure our office provides appropriate support for the student, please complete this form online at www.macomb.edu - keyword search: verification form. If it is necessary to complete this form by hand, please print neatly.

Last Name: First Name: Initial:

Birth Date: Date of Diagnosis:

Diagnosis:

Describe the symptoms the student displays at present and the expected duration, stability or progression of the condition.

List any current treatments, medications (including dosages, frequency and side effects), devices, or services the student is receiving. Has the student adhered to the medication / treatment?

Indicate frequency and length of absences from campus for treatment:

Indicate any expected issues with treatment compliance while the student is in the college environment, including plans to obtain prescription medications.

Describe the likely impact of the student's disability in the following areas of college life. Please indicate the level of impaired functioning that might be expected. Issues might include fatigue, poor attention, poor memory, ect.

Living arrangements:

Campus mobility:

Classroom learning:

Studying, reading,writing:

Social activities:

Please indicate accommodations that may be helpful for the student.. Each recommendation should include an explanation of its relevance to the diagnosis or area of functional limitation. Include a statement of the level of need for the accommodation.

Professional Signature Date

Printed name and title

Address City State Zip Code

Phone Number Fax Number e-mail address

Thank you for assisting us in developing a level of support that will allow the student to take full advantage of college life at Macomb Community College. Any further information you may feel important to share is appreciated.

Please return this form to one of our offices below.

Macomb Community College Center Campus
ATTN: Special Services
44575 Garfield Road
Clinton Township, MI 48038-1139
Phone: 586.286.2237
Fax: 586.286.2295
TTY: 586.286.2238
Direct VP (Deaf): 866.957.1377
Local VP (Hearing): 586.649.3942

Macomb Community College South Campus
ATTN: Special Services
14500 E. 12 Mile Road
Warren, MI 48088-3896
Phone: 586.445.7420
Fax: 586.498.4033
TTY: 586.445.7498
Direct VP (Deaf): 866.957.2172
Local VP (Hearing): 586.447.7936

Release of Information

I, __________

, hereby authorize the exchange and release of the above confidential information to the Special Services Office at Macomb Community College for the purpose of determining my eligibility for educational accommodation.

Student Signature Date

Witness Signature Date