Office for Disability Services
Southern Maine Community College
2 Fort Road
South Portland, ME 04106

Phone: (207) 741-5832 **or**
(207) 741-5923
Fax: (207) 741-5678

Services for Students with Diagnosed Disability

Medical or Physical Disabilities – PROVIDER FORM

Student Name: _____ **DOB**: _____

1. Diagnosis: _____
   _____
2. Date of diagnosis:_____
   Last date of contact with client: _____
3. Please rate severity of the disability on a scale of 1(mild) to 10 (severe) _____
4. Is the condition variable over time? _____Yes ___No
   Please, explain:
   _____
   _____
   _____
5. Is the condition considered chronic? _____Yes ___No
   If NO, expected recovery time: _____
6. Provide information regarding the student's current presenting concerns and symptoms:
   _____
   _____
   _____
   _____

7. Explain how the symptoms related to the student's disorder are significant enough to substantially limit one or more major life activity (e.g. learning, eating, walking, interacting with others, etc.) in the academic and on-campus residential settings.

_____
_____
_____
_____

8. Explain how the disability may affect the student's ability to function in the academic setting, e.g. reading, comprehension, memory, writing, notetaking, test-taking, endurance and attention.

_____
_____
_____
_____

9. If available, describe the long term treatment plan:

_____
_____
_____
_____

10. Describe any treatments, medications, therapies, assistive devices or services the student is currently using. Specify their effectiveness and any side effects that may impact the student's physical access, and/or perceptual or cognitive performance.

_____
_____
_____
_____

11. If there are flare-ups or episodes of the disorder, how often do they occur and how long do they last?

_____
_____
_____
_____

12. If certain conditions contribute to the flare-up or episode, please explain.

_____
_____
_____

13. Determination of reasonable accommodations in the academic setting will be decided by the SMCC Disability Support Services professional after review of disability documentation. Suggestions and/or recommendations are welcome along with an explanation of the relevance related to the diagnosis.

_____
_____
_____
_____
_____

Professional Information:

Name: _____

Title: _____

Credentials: _____

Contact information: _____

_____

_____

Signature of professional: _____

Date: _____

PLEASE RETURN THIS FORM TO:

Southern Maine Community College
Office for **D**isability **S**ervices
2 Fort Road
So. Portland, Maine 04106
Phone: (207) 741-5923
Fax: (207) 741-5678
Email: disabilityservices@smccme.edu
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