QUINCY COLLEGE | PLYMOUTH & QUINCY CAMPUSES

FOCUSED ON TEACHING & LEARNING, ONE STUDENT AT A TIME
Quincy Campus, 1250 Hancock Street, Quincy, MA 023169 Suite 508
Plymouth Campus, 36 Cordage Park, Plymouth MA 02360 Suite 220

DISABILITY SERVICES OFFICE
DISABILITY SERVICE OFFICER: 617- 405-5915 FAX: 617-984-1792
http://www.quincycollege.edu/departments/disability-services

STUDENT AUTHORIZATION TO RELEASE INFORMATION FORM

To:

Date:

I am requesting services from the Disability Services Office (DSO) at Quincy College. In order to receive services the DSO requires documentation of my disability. Services at the DSO are solely based on diagnostic documentation and once this information is in place it will be used to develop a service plan for me.

I hereby authorize you to complete the attached Disability Disclosure Form and release it to the DSO.

I also authorize you to speak with my DSO Specialist in consultation to provide future services. Thank you for your assistance in this matter.

Sincerely,

_____ _____

Student Signature Date

_____

Print Name

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DISABILITY DOCUMENTATION FORM

The licensed clinician or health care provider **who is treating this patient for the diagnosis identified** in this document **must** complete this form.

Student's Name: _____

Clinician's Name: _____

State Licensure/ Certification #: _____

Area of Specialty: _____ Clinician's phone#: _____

The person named on this form is requesting services from the Disability Services Office. The DSO offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act of 1990 (ADA). Under the ADA guidelines a person with a disability is one with a physical, mental, emotional or chronic health impairment that ***substantially limits*** one or more major life activity such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADA disability criteria: Yes ☐ No ☐

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disorder.

Diagnosis/Description of Psychiatric Disorder or Disability: **Please provide full DSM-V code**_____

The extent of the disorder is: ☐ Mild ☐ Moderate ☐ Severe

Initial Date of Diagnosis: Date of last clinical contact:_____

Expected duration of disorder or disability noted above is:
☐ Permanent/ Chronic ☐ Long term: 3-12 months

What is the frequency and duration of symptoms of the student's condition?

☐ Daily ☐ 1/week ☐ 1-3/week ☐ 1/month ☐ 1-3/year ☐ Seasonal

☐ None – symptoms under control with medication ☐ Other:

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DISABILITY DOCUMENTATION FORM PG2

1. Assessment Instruments and Results: (Please describe the procedures used to establish the diagnosis):

2. Medications: Current medications (dosage and side effects):

3. Long term medication plan:

4. Current compliance with medical plan:

5. History of Hospitalization:

6. Does this person create a threat to themselves or others (explain)?

7. Describe the Functional Impact of Symptoms in the Academic Setting:

8. Is this student aware of any realistic limitations regarding how the disorder may impact his/her academic performance?

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9. Suggested Accommodation:

10. Additional information:

Clinician Signature: _____Date:_____

Please fax completed document to 617-984-1792.

Submit