

MERIDIAN COMMUNITY COLLEGE

DISABILITY SUPPORT SERVICES

Disability Verification

Instructions: This form must be completed by the provider prior to request for accommodations. All information must be provided before eligibility will be considered; no empty blanks.

Applicant's Name: _____ Birthdate: _____

Provider's Name and Credentials: _____

(Provider must be a qualified LD and/or ADHD diagnostician (i.e., Clinical Psychologist, Neuropsychologist, or Psychometrist with specialized training).

TO BE COMPLETED BY THE PROFESSIONAL EVALUATOR

The applicant indicated above has requested special accommodations for services at Meridian Community College. Documentation of the disability is required to support the necessity of the request. Provide documentation of the professionally recognized diagnosis by completing the information requested below. Please provide all information with no empty blanks.

1. Describe the applicant's specific disability diagnosis (i.e., mental, physical, learning):

2. Date of initial diagnosis: _____

3. Diagnostic and Statistical Manual of Mental Disorders (DSM) Code: _____

4. Indicate the specific standardized and professionally recognized test/assessment given (e.g., Woodcock-Johnson, Wechsler Adult Intelligence Scale) and attach a copy of results. *Assessment must be current. Not older than three years from the date this form was completed. Required, cannot be left blank.*

5. Date of assessment identified above: _____

6. Identify scores resulting from testing, interpretation of the scores and evaluations:

7. Indicate recommendations for testing accommodations with stated rationale as to the necessity and appropriateness for the diagnosed disability:

NAME OF PROFESSIONAL: _____ TITLE: _____

This form must be completed and returned to: Gina Mills, CTE Support Services Coordinator/Disability Support Services, Office #123-B, Reed Hall, 910 Highway 19 North, Meridian, MS 39307, Phone: (601)484-8777, Email: gmills@meridiancc.edu.