Accessibility Services
Disability Packet to Request Accommodations

To request accommodations, submit this completed packet (pages 2 and 3) along with the specified supporting documentation as early as possible.

- During peak intake periods (before the fall and spring semesters), submit packets at least 6 weeks before the start of the semester to ensure that your approved accommodations will be in place when classes begin.
- If you would like to request accommodations for multiple disabilities, please submit additional verification forms (page 3) with your packet.
- Specific accommodations cannot be discussed until we receive your complete documentation.
- Once we receive your materials and confirm that you are registered for courses, we will call you to schedule an intake appointment. Incomplete packets cannot be processed.
- You will meet one-on-one with a Disability Counselor to formulate reasonable accommodations. This appointment typically lasts 1 hour.
- To prepare for this meeting, please familiarize yourself with “The Differences between High School and College Accessibility Services” (see our website or brochure).

<table>
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<tr>
<th>Send all packets to</th>
<th>Or hand-deliver</th>
<th>Or fax privately to</th>
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<tbody>
<tr>
<td>Accessibility Services</td>
<td>DH 160 in the Danvers Health Building</td>
<td>(978) 646-5363 in Danvers</td>
</tr>
<tr>
<td>North Shore Community College 1 Ferncroft Rd. Danvers, MA 01923</td>
<td>LW 121 in the Lynn McGee Building</td>
<td>(781) 586-8465 in Lynn</td>
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Do not submit this page with your packet; please keep this page for reference.
Accessibility Services
Self-Identification & Request for Services Form

Name _______________________________    Student # (if known) N00 ____________
Program of Study ________________________ Date of Birth ____________________
Address ____________________________   City __________ St_______ Zip ________
Primary Phone _______________________ Email ______________________________

Are you a new student at North Shore Community College?  ❑ yes ❑ no
Are you a Veteran?  ❑ yes ❑ no
How many credits are you taking?   ______      Preferred campus ❑ Danvers ❑ Lynn
For which semester and year are you requesting services?
❑ Fall 20 __  ❑ Spring 20 __  ❑ Summer Session 1 20 __  ❑ Summer Session 2 20 __

Name of documented disability/disabilities ________________________________
Is there other information related to your disability that you would like to convey?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Accessibility Services
Blind or Low Vision Verification Form

For the Student to Complete:
I ________________________________ (print name) grant permission for my disability-related information to be released to Accessibility Services at North Shore Community College. I understand that this documentation is confidential.

__________________________________________  ___________________________
Signature Date

For the Licensed Professional to Complete: To verify this student’s eligibility for accessibility services and to support the formulation reasonable accommodations, this student must provide current and comprehensive documentation of a disability.

Diagnosis and ICD9 Code __________________________________________________
Date of onset ____________________ Date last seen ________________________

Please describe the student’s level of vision loss and whether it is static or changing.
________________________________________________________________________
________________________________________________________________________

Please describe how the student’s vision loss may affect him or her in a college academic setting.
________________________________________________________________________

Please describe academic accommodations you would recommend for this student. Consideration will be given to your recommendations in combination with provisions of Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990.
________________________________________________________________________

Please attach the results of evaluations used to make the diagnosis, including results with numerical descriptions, dates of testing, and specific names of procedures/instruments used.

__________________________ ____________________________ ______________
Licensed professional’s title office address phone number

_____________________________ ___________________________ __________
Licensed professional’s printed name licensed professional’s signature date