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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| Accessibility Services  
North Shore Community College  
1 Ferncroft Rd.  
Danvers, MA 01923 | DH 160 in the Danvers Health Building | (978) 646-5363 in Danvers |
|                                                        | LW 121 in the Lynn McGee Building | (781) 586-8465 in Lynn |

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
Temporary Disability Verification Form

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

_____________________________    ___________________________    __________
Signature                  licensed professional’s 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 medical condition.
________________________________________________________________________
________________________________________________________________________

Please list medications prescribed to this student for this condition and side-effects (if any) that may impact the student 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.
________________________________________________________________________

__________________________________________________________    ____________________________   ______________
Licensed professional’s printed name                  licensed professional’s signature                 date

________________________________________________________________________
Licensed professional’s title                                   office address                               phone number