



A PUBLIC REGIONAL  
COMMUNITY COLLEGE

### *Disability Services Packet*

In order to adequately meet your educational and academic needs we kindly ask that you complete and return the requested documents at least six weeks prior to the start of the semester for which you expect to receive disability services.

To initiate the process of obtaining services, please complete the following steps:

- 1. Complete the Self-Identification Form (second page of this packet)**  
All students who are requesting services must personally complete this form.
- 2. Complete the Disability Verification Form (third page of this packet)**  
This form (s) are to be completed by a licensed professional who is most familiar with you and your disability/educational needs.
- 3. Attach the current diagnostic measures of assessments if required** (*See Verification Form*).
- 4. Return the completed Disability Packet** (*all requested forms and reports*) to Disability Services for review. All forms must be appropriately completed, submitted collectively at the same time. Incomplete packets cannot be processed.
- 5. Once your complete packet has been received, accepted, and reviewed by Disability Services, you will be contacted by Disability Services to arrange for your Disability Intake Interview.** At that time you will meet with a Disability Counselor who has reviewed your documentation and is familiar with your educational needs. Together, you will work to formulate reasonable accommodations for your academic plan. This initial meeting is interactive and takes approximately one hour to complete.

#### **Submit your completed packet to: Disability Services**

Mail: North Shore Community College  
1 Ferncroft Road  
Danvers, Massachusetts 01923

Office: Danvers Health Building DH101

Fax: (978) 646-5363 or (978) 646-5336

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COMMUNITY COLLEGE

*Disability Services  
Self-Identification Request for Services From*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female

NSCC Email: \_\_\_\_\_ Phone or Cell #: \_\_\_\_\_

Program of Study: \_\_\_\_\_ New NSCC Student  Returning NSCC Student

Semester of Services Requested (First semester in which you require Disability Services)

Fall (Sept.) 20\_\_\_\_\_ Spring (Jan.) 20\_\_\_\_\_ Summer Session I \_\_\_\_\_ Summer Session II \_\_\_\_\_

Credits Enrolled for Requesting Semester: \_\_\_\_\_

Which campus is most convenient for you to meet with a Disability Counselor to process your request for services?

Danvers Campus   
(DH101)

Lynn Campus   
(LW121)

Please identify your specific disability (or disabilities):

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MDVF



**Disability Services**  
Disability Verification Form  
Medical Disability

Student's Name: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

By signing this form, I grant permission for information concerning my disability to be released to North Shore Community College, Disability Services. All documentation of disability information is treated as confidential material.

\_\_\_\_\_  
Student's Signature to Release Requested Information Date

The student whose name appears above has initiated the process of requesting services for a disability at North Shore Community College. In order to determine eligibility as an individual with a disability and to formulate reasonable accommodations to ensure equality of access and opportunity, students are **required** to provide current and comprehensive documentation of their disability to Disability Services for formal evaluation.

**This form is to be completed by a licensed professional who is most familiar with the student and his/her disability needs. Please attach any current measures of diagnostic assessments that may assist in the determination of services.**

Diagnosis & ICD9 code: \_\_\_\_\_  
Date of onset: \_\_\_\_\_ Date last seen: \_\_\_\_\_

Description of applicant's medical condition:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any medications prescribed for this condition and any side effects that may affect the student in a post-secondary setting.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any academic accommodations that you would recommend for this student. Please note that 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 1990.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Professional's Name and Title (Print): \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Office Phone: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your cooperation!