



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

INSR



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*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):

PDVF



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Disability Services
Disability Verification Form
Pervasive Developmental 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 (within 3 years) measures of diagnostic assessments that may assist in the determination of services.

Diagnosis (DSM criteria): _____

Date of onset: _____ Date last seen: _____

Level of Severity (circle one) Mild Moderate Severe

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!