



**Visual, Hearing, Medical and/or
Mobility Impairment Documentation
Release of Information Form**

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and it substantially limits some major life activities, including learning. If accommodations, academic adjustments and/or auxiliary aids are being requested, the documentation provided must support the request. Appropriate accommodations will be determined based on the specific information submitted in the documentation.

Please sign this **Release of Information Form** and submit it with the required **Visual, Hearing, Medical and/or Mobility Impairment Documentation Form** completed by a qualified professional evaluator to:

Disability Services
Chippewa Valley Technical College
620 West Clairemont Avenue
Eau Claire, WI 54701-6162
715-833-6234 • Fax: 715-833-6470

I, _____ hereby authorize the release of requested information to the Disability Services Office at Chippewa Valley Technical College for the purpose of determining my eligibility for educational accommodations. Authorization remains in effect for **one (1) year** from the date of my signature.

I understand that I have the right to refuse to sign this authorization form and it may be revoked in writing at any time prior to the disclosure of this information.

Re-disclosure Notice: The information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by HIPAA.

Student Signature

Date

Date of Birth: _____



**Visual, Hearing, Medical and/or
Mobility Impairment
Documentation Form**

This information must be provided and signed by a licensed physician or other qualified professional.

Student Name: _____ **DOB:** _____

1. Medical Diagnosis of Disability:

2. Date of Most Recent Medical Evaluation:

3. Severity/Limitations of Disability:

4. Assessment procedures or evaluation of instruments used to make this diagnosis; including results (please attach assessments/evaluations relative to college accessibility):

a. _____

b. _____

c. _____

d. _____

5. Disability related needs, including recommendations for academic accommodations, adjustments and/or auxiliary aids at the post-secondary level to determine what accommodations are appropriate, (i.e., attendance, carrying books/tools, dexterity, sitting, walking, climbing steps, writing/note taking, word processing, full credit load, and test taking):

- a. _____

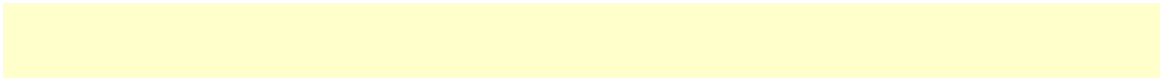
- b. _____

- c. _____

- d. _____

6. Describe any medication side effects that may be anticipated:

7. Describe the prognosis and anticipated duration of the limitations described above:



Physician's Name _____ License # _____
(please print)

- OR -

Other Professional's Name & Title _____
(please print)

Address _____ Phone _____

Signature _____ Date _____