SF SANTA FE COLLEGE

DISABILITIES RESOURCE CENTER (DRC)

Deaf/Hearing Impairment Verification Form

Documentation of a disability is necessary for a student to establish their eligibility for academic adjustments, auxiliary aids and services while at Santa Fe College. The following documentation requirement complies with Section 504 of the Rehabilitation Act of 1973 and Title II of the Americans with Disabilities Amendments Act. The Disabilities Resource Center requires a student who self-identifies as having a disability to provide current (i.e. within the last three years) and comprehensive documentation that verifies a chronic disabling disorder and identifies functional impairments arising from that disorder. Such documentation must be prepared by a healthcare provider who is not a family member of the student and who is qualified by professional training and practice to diagnose and treat the disorder. The confidentiality of all documents submitted to the Disabilities Resource Center are protected under the Family Educational Rights and Privacy Act (FERPA). If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted for documentation instead of this form.

Information To Be Completed by Student

Last Name _____ First Name _____ MI _____ Date of Birth _____

Street Address _____ City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Release of Information Authorization from Student/Patient

I, hereby authorize (Enter Name of Healthcare Provider) _____ to release the following information to the Disabilities Resource Center at Santa Fe College for the purpose of determining my eligibility for academic adjustments, auxiliary aids, and services while I am a student at the college.

Student's Signature _____ Student ID# _____ Date _____

If student is under 18 and/or release is signed by person other than student, state relationship and authority to do so.

Signature of Person on Behalf of Student _____ Relationship to Student _____

Legal Authority _____

Verification Information To Be Completed by Healthcare Provider

Diagnostic and Treatment Information

Is the student currently under your care? _____

Date of last audiogram or audiology assessment _____

Statement of diagnosis and a brief description of the onset and severity of the hearing loss:

Nature of Hearing Loss/Deafness:

Congenital ☐

Acquired ☐ If checked, please choose one of the following: Pre-lingual ☐ Post-lingual ☐

Describe any situations or conditions that might lead to an exacerbation of the symptoms:

Degree of hearing loss, in decibels, pure tone average of 500, 1000, 2000, and 4000Hz, unaided in each ear.
Please send most resent audiological evaluation/audiogram, as well as speech recognition results and word understanding score

Expected Duration of the Disorder: Temporary (Less Than 6 Months) ☐ Chronic (More Than 6 Months) ☐ Permanent ☐

Severity of hearing loss: Mild ☐ Moderate ☐ Severe to Profound ☐

Status of hearing loss: Stable ☐ Variable ☐ Slowly Progressive ☐ Rapidly Progressive ☐ Undetermined ☐

Describe how this condition may result in functional limitations that are specific to the postsecondary classroom setting:

Identify services and devices currently prescribed or in use:

	Prescribed	In Use	Type and/or Model A (please elaborate)
Hearing Aid or Cochlear Implant	☐	☐	_____
ALD/FM System	☐	☐	_____
Real Time Captioning	☐	☐	_____
Interpreter	☐	☐	_____

Other accommodations and ongoing support required for access in the post secondary education environment:

Information To Be Completed by Certifying Healthcare Provider

I certify, by my signature below, that I have professional knowledge of or conducted or formally supervised and signed or co-signed the diagnostic assessment and treatment of the student/patient named above.

Below please sign, date and fill in all other fields completely using PRINT or TYPE

Provider Signature _____ Date _____

Provider Name (Print or Type) _____ Specialty _____

License or Certification No _____ State Issuing Licensure or Certification _____

Office Address _____ City _____ State _____ Zip _____

Office Phone Number _____ Office Fax Number _____

All Documentation Is Confidential And Should Be Submitted To:

Disabilities Resource Center
Santa Fe College 3000 NW 83rd Street, Bldg. S, room 229
Gainesville, FL 32606
Phone: 352-395-4400
Fax: 352-395-4100
E-mail: disability.info@sfcollege.edu

Visit our web site: http://www.sfcollege.edu/student/drc/