Hostos Community College ARC ACCESSIBILITY RESOURCE CENTER

ACCESSIBILITY RESOURCE CENTER
500 Grand Concourse Bronx, NY 10451, M-216
Telephone/Fax: (718) 518-4454/4433
Email: arcstaff500@gmail.com

DISABILITY / FUNCTIONAL LIMITATIONS / ACCOMMODATIONS DOCUMENTATION

STUDENT NAME (Print): _____

I authorize the release of this information to the Accessibility Resource Center at Hostos Community College

Signature: _____ Date: _____

The above named student has applied for services and accommodations that are provided by the College in compliance with the **Rehabilitation Act of 1973 and Americans with Disabilities Acts**. The **ADA** defines a person with a disability as someone with a physical or mental impairment that substantially limits one or more major life activity, such as; seeing, speaking, hearing, walking, breathing, performing manual tasks, caring for oneself, learning and working.

Please specify below functional limitations or restrictions that are the result of the student's medical or psychological condition. Some examples are: limited mobility or use of hands; impaired vision, hearing or speech; memory/concentration difficulties; cognitive impairments; chronic fatigue; difficulty responding to stress or interacting with others; difficulty using stairs or with prolonged sitting/standing. We are especially interested in knowing if there are any limitations of the student's test-taking abilities.

BE SPECIFIC IN YOUR DESCRIPTIONS AND EXPLANATIONS. PLEASE TYPE OR PRINT CLEARLY.
ACCOMMODATIONS CANNOT BE PROVIDED WITHOUT APPROPRIATE DOCUMENTATION.

Diagnosis / Description of Disability / Condition: (if a Psychiatric disability, you please use DSM-V descriptors)

_____

_____ **Date of Diagnosis:** _____

Functional Limitations, e.g., **physical** – hand function, mobility, hearing, vision limitations; **cognitive** – learning, memory, concentration problems; **interpersonal** – difficulty interacting with others; **psychological** (be specific in all indications)

_____

_____

What accommodations, if any, do you recommend? For example, modified instruction or testing, limited physical exertion, use of Assistive Technology, etc.

_____

_____

_____

Characteristics of disability (check appropriate terms): ☐ **Temporary (less than 6 months)** ☐ **Persistent/chronic** ☐ **Stable** ☐ **Slowly progressive** ☐ **Rapidly progressive** ☐ **Improving**

Medications: _____

_____

Is the student expected to be involved in on going treatment? ☐ **YES** ☐ **NO**

PLEASE ATTACH A PROFESSIONAL BUSINESS CARD, LETTERHEAD STATIONARY OR USE AN OFFICIAL STAMP ON THIS FORM.

Name of person completing this form: _____ Title: _____

Agency/Affiliation: _____ Telephone: _____

Signature: _____ Lic.#: _____ Date: _____

Please use additional pages or provide supplemental medical documents. In order to provide the most comprehensive services and accommodations to the student you may be asked to provide updated documentation in the future.