



**Disability Disclosure Form – Hearing Loss**

Date: \_\_\_\_\_

Dear (Clinician Name) \_\_\_\_\_:

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

- I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.
- I authorize you to attach a copy of my current audiology report, as requested.
- I also authorize you to speak with my DRC Specialist in consultation to provide future services.

**Please submit the completed form to:**

**Ms. Debbi Auerbach, Service Coordinator**

**By mail:**

Northeastern University  
Disability Resource Center  
20 Dodge Hall  
360 Huntington Avenue  
Boston, MA 02115

**By confidential fax:** 617-373-7800

You may contact Ms. Auerbach with any questions (phone: 617-373-2675 / TTY: 617-373-2730 or email: d.auerbach@neu.edu).

Thank you for your timely assistance with this matter.

Sincerely,

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Medical Record ID#





- **Level of hearing loss is:**     Mild     Moderate     Severe     Profound
  
- **Assessment Instruments and Results** (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):
  
  
  
  
  
  
  
  
  
  
- **Please describe the functional impact of the disability/symptoms on this individual's:**
  - Daily life** (include any limitations related to personal care, social interactions, manual tasks, etc.)
  
  
  
  
  
  
  
  
  
  
  - Academic environment** (note: please consider situations in and out of the classroom)



Please comment on the following items as applicable:

▪ **If Deaf-Blind, rate Mobility and Orientation (*travel skills*):** **Novice**      **Intermediate**      **Advanced**  
(Please include current vision evaluation report; see Disclosure Form for Blind/Vision Impairment)

▪ **Communication method (indicate all that are used):**

- |   |   |
|---|---|
| <input type="checkbox"/> American Sign Language               | <input type="checkbox"/> Oral: English. Other Language: _____ |
| <input type="checkbox"/> Signed English                       | <input type="checkbox"/> Tactile Sign Language                |
| <input type="checkbox"/> Other Signed Language (e.g .Spanish) | <input type="checkbox"/> Close Vision Signing                 |
| <input type="checkbox"/> Cued Speech                          | <input type="checkbox"/> Other : _____                        |

▪ **This person uses any or all of the following (indicate specific device or service):**

- |  |  |
|--|--|
| <input type="checkbox"/> Hearing Aids<br>___ Bilateral<br>___ Unilateral<br>(type/model: _____)                                | <input type="checkbox"/> Service Animal (Hearing Dog)                          |
| <input type="checkbox"/> Cochlear Implant. Type: _____<br>Month/Year of surgery: _____<br>Month/Year of most recent map: _____ | <input type="checkbox"/> Assistive Listening Device<br>(please specify: _____) |
|  | <input type="checkbox"/> Other Technology/Aids<br>(please specify: _____)      |

▪ **Suggested accommodation(s) for the academic setting:**

- |  |   |
|--|---|
| <input type="checkbox"/> Alternate Text Formats (Deaf-Blind) | <input type="checkbox"/> Note-taking                                |
| <input type="checkbox"/> Assistive Listening Device          | <input type="checkbox"/> Oral Transliteration                       |
| <input type="checkbox"/> Captioned Media                     | <input type="checkbox"/> Preferential Seating                       |
| <input type="checkbox"/> Housing (circle any that apply)     | <input type="checkbox"/> Sign Language Interpreting/Transliterating |
| ○ Signaling: Visual and/or Vibration                         | <input type="checkbox"/> Speech to Text Services                    |
| ○ Service Animal Relief Area                                 | <input type="checkbox"/> Other: _____                               |
| ○ Other: _____   |   |

▪ **Additional information:**

Clinician/Professional Sig nature

Date

**NOTE: Please attach a current Audiology Report to this Disclosure Form**