Disability Disclosure Form – Chronic Disorder

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 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#
Disability Disclosure Form – Chronic Disorder

This form must be completed by the licensed clinician or health care provider who is treating this patient for the diagnosis identified in this document. In order to best serve the student, please thoroughly complete all requested information.

Patient’s/Client’s Name: __________________________________________

Clinician’s Name: ________________________________

Clinician’s State Licensure/ Certification #: _______________________

Area of Specialty: ____________________________ Clinician’s phone #: ______________________

The Disability Resource Center (DRC) has been a part of the Northeastern University campus since 1978. We recognize the inherent value and diversity of all individuals. The sole mission of the DRC is to ensure that those students with disabilities have equal access to the academic experience at Northeastern University. The DRC provides students with appropriate services and can advocate as needed within the wider University community. At the same time, our goal is to promote independence and self-advocacy within each individual. The DRC does not provide healthcare, therapeutic counseling or case management/coaching; these services are provided by other departments within the University.

The person named on this form is requesting services from the Disability Resource Center. The DRC offers services to students who are considered permanently disabled under the mandates of the Americans with Disabilities Amendments Act of 2008 (ADAAA).

By completing this document I verify that the person named in this document has a substantially limiting disorder that meets the ADAAA disability criteria noted below.

Under the ADAAA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (this is not an exhaustive list).

*Website: www.northeastern.edu/drc * Phone: (617) 373 2675 V, (617) 373 2730 TTY * Fax: (617) 373 7800*
Please thoroughly complete this form to document the substantial limitations that are linked to this disability.

1. Diagnosis/Description of Disability: ____________________________

2. Please provide full DSM or ICD-9 code: ____________________________

3. Initial Date of Diagnosis: ___________ 4. Date of last clinical contact: ___________

5. The extent of the disability is: ☐ Mild ☐ Moderate ☐ Severe

6. What is the frequency and duration of symptoms of the student’s condition?
   a. ☐ Daily ☐ 1x/week ☐ 1-3x/week ☐ 1x/month ☐ 1-3x/year ☐ Seasonal
   b. ☐ None – symptoms under control with medication ☐ Other: __________________

7. Assessment Instruments Used and Results (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):

8. Please describe the substantially limiting symptoms which impacts this individual’s functional abilities in the following areas:
   a. In the classroom or lab. Please describe the current impact of this student’s disability on his/her ability to perform in-class or lab work. Please consider, as relevant, the impact on tasks including but not limited to: paying attention to lecture, taking notes, responding to oral or written questions, participating in group work, and following instructions.

The extent of these symptoms are: ☐ Mild ☐ Moderate ☐ Severe
b. During exams/tests/quizzes/timed class work. Please describe the current impact of this student’s disability on his/her ability to perform during testing or on timed work. Please consider, as relevant, the impact on tasks including but not limited to: maintaining concentration, disregarding distractions, organizing responses, and speed of responses.

The extent of these symptoms are:  □ Mild  □ Moderate  □ Severe

c. On individual or group work and assignments outside of class. Please describe the current impact of this student’s disability on his/her ability to perform academic tasks outside of class. Consider, as relevant, the impact on tasks including, but not limited to: responding to oral or written questions, participating in group work, following instructions, maintaining concentration, disregarding distractions, and organizing responses.

The extent of these symptoms are:  □ Mild  □ Moderate  □ Severe

d. On campus life (include any limitations related to self/personal care, interactions with roommates/peers, non-classroom settings e.g. residence hall/dining hall social settings, etc.)

The extent of these symptoms are:  □ Mild  □ Moderate  □ Severe
9. Please describe the current treatment and medication regimen (including treating clinicians, frequency of treatment, medications, and side effects):

- Additional information:

__________________________  _________________________
Clinician/Professional Signature  Date

Please note: This documentation will need to be updated annually by the current treating clinician.
Revised: 1/24/14

*Website: www.northeastern.edu/drc  Phone: (617) 373 2675 V, (617) 373 2730 TTY  Fax: (617) 373 7800*