



**Southeast Arkansas College**  
**1900 Hazel**  
**Office of Disability Services**  
**Pine Bluff, Arkansas 71603**  
**Phone/Fax: 870-850-2183**

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## **Hearing Disability Verification Form**

The Office of Disability Services (ODS) provides academic services and accommodations for students with diagnosed disabilities. The documentation provided must demonstrate a disability covered under Section 504 of the Rehabilitation Act of 1973 and the Title II of the Americans with Disabilities Act (ADA) OF 1990. The ADA defines a disability as a physical or mental impairment has substantially limits one or more major life activities. "Major life activities" include caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, sitting, standing, lifting, and working, as well as mental and emotional processes such as thinking, concentrating, and interacting with others. For a student to be considered eligible to receive academic accommodations, the documentation must show the functional limitations that impact the individual in the academic setting.

The ODS requires current and comprehensive documentation to determine appropriate services and accommodations. As a guideline, Southeast Arkansas College (SEARK) generally requires documentation prepared within the last three (3) years. SEARK reserves the right to request updated or more extensive evaluation. The outline below has been developed to assist the student working with the treating or diagnosing healthcare professional(s) in obtaining the specific information necessary to evaluate eligibility for academic accommodations

- The healthcare professional(s) conducting the assessment and/or making the diagnosis must be qualified practitioner. These persons are generally trained, certified or **licensed audiologist, ears, nose, and throat specialist, or other qualified medical specialist.**
- All parts of the form must be completed as thoroughly as possible.
- The healthcare provider should attach any reports which provide additional, related information. 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.
- **After completing this form, sign it, complete the healthcare provider information section on the last page and mail or fax it to the ODS at the address provided above on this form.** The information that you provide will NOT become part of the student's educational record, but it will be kept with the student's file at ODS, where it will be held strictly confidential.

## STUDENT INFORMATION

First name \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Date of birth \_\_\_\_\_ Last four digits of SSN \_\_\_\_\_

Status (Check one)  current student  transfer student  prospective student

Cell phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Local phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

## Diagnostic Information

Please provide the following information:

1. Date of Diagnosis \_\_\_\_\_

2. Date of first contact with the student: \_\_\_\_\_

3. Date of last contact with student: \_\_\_\_\_

4. Is the student currently under your care?

Yes  No

5. What is the degree of the hearing loss (mild, severe, profound)? Please include a copy of the most recent audiogram.

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6. Describe how this hearing disability may affect this student both academically and/or physically (functional limitations)

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7. What means of communication has this student used in the past? Please describe the student's skill in the use of his/her communication skills.

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8. What recommendations do you have for accommodations and/or auxiliary aids, i.e. Phonic Ear, note-taker, real time captioning, sign language interpreting, etc in an academic setting? Please state your rationale for the accommodations and/or auxiliary aids you have recommended.

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9. Are there any other associated disabilities? Please describe.

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### Health Care Provider's Signature Information

Print, sign, and date below and fill in the other fields completely. *Please print or type*

Provider's name(Print) \_\_\_\_\_

Provider's signature: \_\_\_\_\_ Date \_\_\_\_\_

Title: \_\_\_\_\_

License or Certification # \_\_\_\_\_

Address:

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Phone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Fax number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_