

ADA Documentation Confirmation Form

It is the policy of THE TEMPLE: A Paul Mitchell School to comply with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act which are Federal laws that prohibit discrimination on the basis of disability. THE TEMPLE does not discriminate on the basis of disability against a qualified person with a disability in regard to application, acceptance, grading, advancement, training, discipline, graduation, or any other aspect related to a future professional's participation in a program of THE TEMPLE. THE TEMPLE will provide reasonable accommodations to future professionals with disabilities.

THE TEMPLE: A Paul Mitchell Partner School must provide *academic adjustments, auxiliary aids and reasonable accommodations* to future professionals with disabilities, that are necessary to ensure future professionals are not denied the benefits of, or excluded from participation in, THE TEMPLE's program. THE TEMPLE must make modifications to its academic requirements that are necessary to ensure that the requirements do not discriminate against future professionals with disabilities.

Future professionals with disabilities who wish to request reasonable accommodations (including academic adjustments, auxiliary aids, or modifications) must provide documentation of disability from an appropriate professional, which depends on the nature of the disability.

<p>As a future professional of THE TEMPLE: A Paul Mitchell Partner School, I have been informed of my responsibilities under the American With Disabilities Act and notified of the campus ADA Coordinator.</p>	<p>INITIAL</p>
<p>I confirm that I have been physically given a copy of the ADA Application for reasonable accommodation and am aware of where additional copies can be located on THE TEMPLE web site:</p> <p>https://pmthetemple.edu/wp-content/uploads/2021/03/MAR2021_Frederick_ADA_Disability_Verification_Form.pdf</p>	<p>INITIAL</p>
<p>I AGREE that it is my responsibility to return the properly completed documentation to the ADA coordinator. I understand that I will then receive a confirmation email communication that it has been received and a time will be scheduled to meet to review the requests. Failure to turn in a properly completed ADA Request for Accommodation will result in THE TEMPLE not being able to comply with my request.</p>	<p>INITIAL</p>

<p>PRINT NAME:</p>
<p>SIGNATURE:</p>
<p>DATE:</p>



WRITE US

22 W Church Street
 Frederick, MD 21701

CALL US

301-682-7550

CHECK US OUT

www.pmthetemple.edu

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Disability Verification Form

LETTER TO TREATING PROFESSIONAL

DATE: _____

Dear Health Professional:

The individual listed on the attached **THE TEMPLE: A Paul Mitchell Partner School Disability Verification Form** has requested accommodation(s) for his/her physical or mental impairment(s). To help us evaluate the requested accommodation, we ask that you complete the enclosed Disability Verification Form.

Eligible conditions and the **authorized health professionals** who may verify them and sign the Disability Verification Form on the attached Disability Definitions and Documentation, page 4.

INSTRUCTIONS

1. **Items 1–5 — These items on the Disability Verification Form must be completed.**
2. **Item 2 — At least one “major life activity”** limitation must be checked in order for the student to be eligible.
3. The Disability Verification Form must be **completed and signed by the health professional** qualified to diagnose and treat the specific condition. (*Refer to the attached Disability Definitions and Documentation.*)
4. **Please return the Disability Verification Form by mail**, unless requested otherwise by the student. (*Attach any medical, psychological, and/or educational documentation.*)

THE TEMPLE: A Paul Mitchell Partner School
ATTN: Emily Kline
22 W Church Street
Frederick, MD 21701

Please indicate any restrictions or other recommendations, if appropriate.

The completed Disability Verification Form must be returned to the school’s ADA coordinator before the student can receive disability-based accommodations.

Thank you for your prompt attention on behalf of your patient. If you have questions, please call our school’s ADA coordinator at **240-680-9357**.

Sincerely,

Emily Kline
Future Professional Advisor
emilyk@pmthetemple.edu
240-680-9357

ADA Coordinator

Disability Verification Form

INSTRUCTIONS TO STUDENT

In order for **THE TEMPLE: A Paul Mitchell Partner School**, to evaluate your request for accommodation(s), please provide us with a letter from your healthcare professional(s) substantiating your physical or mental impairment(s), how that impairment limits a major life activity, and addressing how the requested accommodation will ameliorate the limitations of those impairment(s). For your convenience, we are enclosing our template Disability Verification Form that you can ask your healthcare professional to complete and return to us. You are not required to use this form, but we encourage you to do so. Upon receipt of the requested documentation, will promptly evaluate your request.

- STEP 1:** Complete the Student Information section of the Disability Verification Form, page 3, either online prior to printing **or** print the Disability Verification Form and complete the section by hand.
- STEP 2:** Print this material (*four pages*), which includes the letter, the instructions, the form, and the disability definitions.
- STEP 3:** Provide this material to your treating professional.

Disability Verification Form

STUDENT INFORMATION

Name: _____ ID Number: _____ Birthdate: _____
Address: _____ City: _____ Zip: _____
Personal Phone Number: _____ E-mail: _____

TO BE COMPLETED BY LICENSED OR CERTIFIED PROFESSIONAL

Licensed or Certified Professional Name: _____
Address: _____ City: _____ Zip: _____
Telephone Number: _____ E-mail: _____

Please provide the following information in full in order to qualify the student for eligibility and help determine the reasonable educational and physical accommodations:

1. What is the nature of his/her physical or mental impairment(s):

2. This condition substantially limits the following major life activities: (This section is required)

- Moving Walking Manual tasks Bending Standing Lifting Breathing Concentrating
 Seeing Reading Hearing Communicating Sleeping Eating Caring for one's self

3. How will his/her physical and/or mental impairment(s) substantially impact his/her major life activities?

4. What, if any, accommodations do you recommend be provided to help ensure his/her equal access and/or full opportunity to participate in our education program? For each recommendation, please explain how that accommodation will ameliorate a substantial limitation:

5. The condition is: Stable Prone to exacerbation

6. Duration of disability: Permanent/chronic Temporary ... SELECT ONE: 45 days or more
 Less than 45 days
Expected duration: _____

I understand that the information provided will become part of the student record subject to the federal Family Educational Rights and Privacy Act of 1974 and may be released to the student on his or her written request.

Signature: _____

Title/License Number: _____ **Date:** _____

If the above information is completed by an individual other than the professional who made the diagnosis, please provide the name and the telephone number of the individual who completed the Disability Verification Form:

Signature: _____

Title/License Number: _____ **Date:** _____

Disability Verification Form

DISABILITY DEFINITIONS AND DOCUMENTATION

Supporting medical documentation for individuals requesting reasonable accommodation(s) should specify that a student has a physical or mental impairment and how that impairment substantially limits one or more major life activities.

In general, supporting medical documentation must be dated less than three years from the date a student requests a reasonable accommodation, and must be completed by a qualified professional in the area of the student's disability, as enumerated below:

Disability	Definition	Qualified Professionals	Important Notes
Physical Disability	Visual, mobility, or orthopedic impairment	MD, OD	
Visual Impairment	Total or partial loss of sight: in best eye, with best correction, 20/200=legal blindness or 20/70 =partial sight	MD, ophthalmologist, optometrist	
Mobility, Orthopedic Impairment	Serious limitation in locomotion or motor function	M.D, O.D., see comments	DC accepted for disabilities related to the back
Hearing Impairment: GENERAL	Loss of hearing, which impedes the communication process essential to language, educational, social, and/or cultural interactions	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past year
Hearing Impairment: DEAF	Requires use of communication mode other than oral, including sign language	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past year
Hearing Impairment: HARD OF HEARING	1. Severe=avg. loss in better ear, 55 db. 2. Mild-Moderate=avg. unaided loss in better ear 35-54 db.; aided, 20-54 db. or greater 3. Speech discrimination less than 50 percent 4. Documentation of rapid loss	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past year
Speech and Language Impairment	Speech/language disorders of voice, articulation, rhythm, and/or the receptive and expressive language processes	Licensed speech professional	NOT caused by acquired brain injury, physical, psychological, or hearing impairments
Learning Disabilities	Cognitive ability test standard scores (usually WAIS III or WJ III), achievement test standard scores (usually the WJ III or the WIAT II)	PhD psychologist, college learning disability specialist, other appropriate professional	Submit the verification documents from the past year
Acquired Brain Impairment	Deficit in brain functioning caused by external or internal trauma, resulting in loss of cognitive, communicative, motor, psychosocial, and/or sensory-perceptual abilities	MD neurologist, neuropsychologist	Submit recent neuropsych report, if available; not applicable: conditions induced or present at birth, or progressive and/or degenerative in nature
Developmentally Delayed Learner	A DDL student is one who exhibits the following: a) below average intellectual functioning; and b) potential for measurable achievement in the instructional setting	Submit test results or regional center certification	Submit the verification documents from the past year
Psychological Disability	Persistent psychological or psychiatric disorder, or emotional or mental illness, moderate or severe on Axis I or II in the DSM, interferes with a major life function, poses an educational limitation	Psychiatrist; PhD psychologist, LMFT or LCSW (indicate license number)	Not qualified: DSM V codes, developmental disorders, sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance abuse disorders resulting from current illegal use
ADD/ADHD	Meets the DSM diagnostic criteria and poses an educational limitation	Psychiatrist; PhD psychologist, LMFT or LCSW (indicate license number)	
Other Disabilities	Health conditions that limit a major life activity, present an educational limitation, and require support services or instruction	Licensed certified professional who is legally qualified to diagnose the disability in question	Examples include, but are not limited to: heart conditions, renal failure, tuberculosis, AIDS, diabetes

For further information on qualifying disabilities and/or signature and documentation requirements, contact the school's ADA coordinator, Emily Kline at 240-680-9357. Personal information recorded on the Disability Verification Form will be kept confidential in order to protect against unauthorized disclosure. Portions may be shared with Paul Mitchell Schools or other state or federal agencies, in such a manner as to comply with applicable statutes regarding confidentiality, including the Family Educational Rights & Privacy Act (20 U.S.C. 1232(g)) pursuant to Sect. 7 of the Federal Privacy Act (P.L. 93-578, 5 U.S.C. 552a, note). The information is collected pursuant to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Request for Reasonable Accommodations

THIS FORM MUST BE COMPLETED BY THE REQUESTING INDIVIDUAL

STUDENT INFORMATION

Name: _____ ID Number: _____ Birthdate: _____

Address: _____ City: _____ Zip: _____

Personal Phone Number: _____ E-mail: _____

Identify the nature of your physical and/or mental impairment(s) for which you are requesting accommodations:

Identify how your physical and/or mental impairment(s) will affect your ability to satisfy the School's requirement(s):

Identify the accommodation(s) you are requesting:

List all possible alternative accommodations:

Requesting Individual's Signature: _____ **Date:** _____

ADA Coordinator Receipt of Request Date: _____

You may be asked to provide medical documentation substantiating your physical and/or mental impairment(s) and/or the need for the requested accommodation(s), including but not limited to when the limitation or impairment is not readily apparent and/or a requested accommodation does not clearly relate to your impairment(s). Any information you provide will be kept confidential and used solely to determine that the accommodation is needed.