



Disability Verification Form

LETTER TO TREATING PROFESSIONAL

[INSERT DATE]

Dear Health Professional:

The patient named on the attached _____ Paul Mitchell The School - Pasadena **Disability Verification Form** has requested that his or her disability be verified. This documentation is for the purpose of qualifying him or her as eligible for disability-related services and is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Locate the 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.)*

Paul Mitchell The School - Pasadena
Nu To
825 E. Green Street, Pasadena, CA 91101

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 _____ (626) 284-2863 _____.

Sincerely,

Nu To
Paul Mitchell The School - Pasadena

ADA Coordinator



Disability Verification Form

INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Paul Mitchell The School - Pasadena, a student must submit the Disability Verification Form documenting a physical and/or psychological disability. The Disability Verification Form must be completed and signed by a licensed/certified professional qualified to diagnose and treat the condition(s).

- 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: _____
Telephone Number: _____ Cell Phone Number: _____ E-mail: _____

TO BE COMPLETED BY LICENSED OR CERTIFIED PROFESSIONAL

Licensed or Certified Professional Name: _____
Address: _____ City: _____ Zip: _____
Telephone Number: _____ Cell Phone 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. Diagnosis: **A:** _____ **B:** _____
If applicable, DSM IV Code: _____ Severity: Moderate Severe Residual/Remission

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. Does it impact any of the following? (Optional)
 Stamina Forming/executing plans Social interaction Overcoming obstacles Memory

4. List other limitations/information helpful in determining accommodations in an educational setting: _____

5. The condition is: Stable Prone to exacerbation

6. Duration of disability: Permanent/chronic Temporary If 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:

Name: _____ Title: _____ Telephone: _____

TO BE COMPLETED BY PAUL MITCHELL SCHOOLS STAFF

Assessment by the appropriate staff **P=** Primary
 Documentation review by outside agency/certified/licensed professionals **S=** Secondary full service (more than one secondary is possible)

ABI: _____ HEARING: _____ MOBILITY: _____ PSYCH: _____ VISION: _____ DDL: _____ LD: _____ OTHER: _____ SPEECH: _____ NONCLAIM: _____



Disability Verification Form

DISABILITY DEFINITIONS AND DOCUMENTATION

Eligibility for disability services is based on an individual's condition, which must: **1** fall within the diagnostic categories listed below; **and 2** impair a major life activity; **and 3** pose an educational limitation for which accommodation is required and appropriate.

Paul Mitchell The School - Pasadena

uses the information requested on the Disability Verification Form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services.

| Disability | Community College 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 | 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 |
| 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 |
| 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 at

(626) 284-2863

. 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

Name: _____
Last First Middle Initial

Once you have completed the Disability Verification Form, submit it to the School Director or ADA coordinator.

Identify your condition(s) and indicate how each condition affects your ability to perform the requirements of the course:

State the accommodation requested:

List all possible alternative accommodations:

Applicant Signature: _____ Date: _____

Receipt of request date: _____

(The School Director or ADA coordinator must complete the request date.)