LETTER TO TREATING PROFESSIONAL

Date:

Dear Health Professional:

The patient named on the attached 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 Rhode Island
   Ashley Medeiros
   30 Chapel View Blvd., Suite 100, Cranston, RI 02920

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 401-946-9920.

Sincerely,

Ashley Medeiros
Paul Mitchell The School Rhode Island

ADA Coordinator
INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Paul Mitchell The School Rhode Island, 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:____ HARING:_____ MOBILITY:____ PSYCH:_____ VISION:_____ DDL:_____ LD:____ OTHER:____ SPEECH:_____ NONCLAIM:_____
The information is collected pursuant to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

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.

For further information on qualifying disabilities and/or signature and documentation requirements, contact the school’s ADA coordinator at 401-946-9920. 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

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.)