

Laramie County Community College
Accommodation Documentation Form
 Office of Student Accommodation Fax (307) 778-1262, Phone (307) 778-1359
 1400 East College Dr. Cheyenne, WY 82007

Student Section

Student Name: _____
 Address: _____
 City: _____ Zip: _____
 Birthdate: _____ Phone: _____
 I authorize the professional designated below to complete this form and return it to LCCC, Disability Support Services
 Student Signature: _____

Please indicate which licensed/certified professional you authorize to provide this information:

Name of Licensed or Certified Professional: _____
 Address: _____ City: _____ Zip: _____
 Phone: _____ License Number: _____

To Be Completed by Licensed or Certified Professional

Please send our office information pertaining to 1) the diagnosis 2) the type of functional limitations the condition may cause in an educational setting.

Diagnosis A: _____
 Date of Diagnosis: _____
 Severity: Severe Moderate Minor
 Is the condition permanent? _____ Temporary, until: _____

Diagnosis B: _____
 Date of Diagnosis: _____
 Severity: Severe Moderate Minor
 Is the condition permanent? _____ Temporary, until: _____

Identify the major life activities or functions that are limited by the condition.

	Degree of Impairment					Degree of Impairment			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Mobility on Campus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attention/Focus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comprehension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Writing Notes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning/Organizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exams	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speaking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Processing Oral Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Processing Visual Information	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Please list any situation(s) that exacerbates the condition:

Recommendations for effective and reasonable accommodations in the educational setting:

I understand that the information provided will become part of the student record, subject to the Federal Family Education Rights and Privacy Act.

Signature

Title/License

Date

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Documentation Requirements

Documentation should be from a licensed/certified professional qualified to diagnose/assess and identify that student's disability. **Documentation must include: Diagnosis, how condition substantially limits one or more life activities, situations that exacerbate the condition, recommendations for effective and reasonable accommodations in the educational setting.**

(High school students or recent graduates, submit most recent IEP and one of the following...)

Type of Disability	Type of Documentation Needed
<p>Acquired Brain Injury (<i>deficit in brain functioning resulting in loss of cognitive, communicative, motor, psychological, and/or sensory/perceptual abilities</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Neurologist, Neuropsychologist or Physician 	<ul style="list-style-type: none"> Cognitive rehabilitation report/neurological assessment/medical report documenting the condition OR Description of the injury and impact on cognitive functions. How might the injury affect the person's participation and performance in a college/school setting? Recommended accommodations.
<p>Intellectual Disability (<i>below average intellectual functioning and potential for measurable achievement in instructional and employment settings</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Psychiatrist or Psychologist 	<ul style="list-style-type: none"> Psychological report documenting limitations, exacerbating conditions, and recommended accommodations, OR Psychological-Educational Report from prior high school
<p>Deaf or Hard of Hearing (<i>loss of hearing function which impedes language, educational, social, and/or cultural interactions</i>)</p> <ul style="list-style-type: none"> Audiologist or Certified Otologist 	<ul style="list-style-type: none"> Current audiogram documenting the condition, OR Have the licensed or certificated professional complete the LCCC DSS Disability Documentation form
<p>Learning Disability (<i>average to above average intellectual ability; severe processing deficit; severe aptitude-achievement discrepancy; and measured achievement</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Educational or Clinical Psychologist, School Psychologist or Psychiatrist 	<ul style="list-style-type: none"> Psychological report documenting the condition, limitations, exacerbating conditions, and recommended accommodations, OR If you have recently finished high school, then request that a "Psychological-Educational Report" be sent to LCCC OSA IEP's rarely include the type of diagnostic information listed above
<p>Mobility Impairment (<i>serious limitation in locomotion and/or motor function</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Physician 	<ul style="list-style-type: none"> Medical report documenting the condition, limitations, exacerbating conditions, and recommended accommodations, OR Have the licensed or certificated professional complete this form.
<p>Psychological/Mental Health Need (<i>persistent psycho- logical/psychiatric disorder; emotional or mental illness</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Psychiatrist, Psychologist MFCC or MSW or Physician 	<ul style="list-style-type: none"> Psychological report documenting the condition, limitations, exacerbating conditions, and recommended accommodations, OR Have the licensed or certificated professional complete this form.
<p>Speech and Language Impairment (<i>disorders of voice, articulation, rhythm, and/or receptive and expressive processes</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Speech and Language Pathologist 	<ul style="list-style-type: none"> Speech/Language report documenting the condition OR Have the Licensed or Certificated professional complete this form.
<p>Visual Impairment (<i>total or partial loss of sight</i>). Seek documentation from:</p> <ul style="list-style-type: none"> Ophthalmologist or Optometrist 	<ul style="list-style-type: none"> Current vision test documenting the condition OR Have the Licensed or Certificated professional complete this form.
<p>Other Conditions (<i>does not fall into any of the above disabilities but indicates a need for support services</i>). Such as: Chronic medical conditions, autism spectrum, ADHD, pregnancy, breastfeeding or other conditions, seek documentation from:</p> <ul style="list-style-type: none"> Psychologist, Psychiatrist, or Physician 	<ul style="list-style-type: none"> Medical or professional report documenting the condition, limitations, exacerbating conditions, and recommended accommodations, OR Have the Licensed or certificated professional complete this form.