

Clinician Disability Certification Form

Student Name: _____ Class Year: _____ DOB: ____/____/____

Address: _____ City/State: _____

Mount Holyoke College offers services on an individual basis to students with documented disabilities. Please certify the student's disability diagnosis and return/fax the form to us as soon as possible to the address listed. This information is confidential and will be used to help determine eligibility for services and accommodations. The information provided will be shared only with members of the Mount Holyoke College administration, health services, counseling services, and faculty involved with coordinating services and providing accommodations.

Please return this form by June 12th for the Fall Semester or December 12th for the Spring Semester. Our ability to respond to students' requests for accommodations is dependent on receiving appropriate documentation. Failure to return completed documentation on time may jeopardize our ability to provide reasonable accommodations and services for students. The College reserves the right to determine what is reasonable accommodation. Service providers will review each student's documentation and work with students individually to determine appropriate and reasonable accommodation.

Forward completed forms and attached information to:

Elisabeth Hogan
Disability Services
Mount Holyoke College
300 Mary Lyon Hall
South Hadley, MA 01075-1487

If you have any questions, you may write or call (413) 538-2550, TTY phone number (413) 538-2860
Fax to: (413) 538-2584 and send hard copy as well

For your reference, our website address is:

www.mtholyoke.edu/go/disabilityservices or www.mtholyoke.edu/go/learningskills

Please Note: To be completed by Health Care Provider.

This Clinician's form may not be completed by student's parents or guardian.

A. Information on Diagnosis

Specific Diagnosis**:

Date of Diagnosis/Time of Onset: _____

Length of Time Working with Student: _____

Most Recent Evaluation: _____

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B. Nature of Disability

Explain the current functional limitations imposed by the condition. Indicate how the disability interferes with or limits any facet of a major life activity, including current participation in courses, programs, residential life, or activities of the College. Include the impact of medication or other treatments.

Specific duration, stability or progression of the condition: _____

Current treatment/follow up plan: _____

Specific recommendations for reasonable accommodations, based on disability:

C. Clinician Information:

Clinician Name (Please Print): _____

Certification/Credentials: _____

State Licensure Number (if applicable): _____

Agency/Institution: _____

Address: _____ City/State: _____

Area Code/Telephone: () _____

Clinician Signature: _____ Date: _____

** For diagnosed Learning Disabilities or Attention Deficit Disorder, enclose a psychoeducational evaluation including test scores and recommendations that are within the past three years.