

**HONOLULU COMMUNITY COLLEGE  
SERVICES FOR STUDENTS WITH DISABILITIES  
PHYSICIAN'S VERIFICATION FORM – ACADEMIC**

<p><b>Confidential</b>                  Rec'd ___/___/___ Comp Req Rep                  Thru: Fall Spring Sum ___/200___</p>
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**Please print clearly. Incomplete forms will not be processed.**  
 Return to HCC Health Office, 874 Dillingham Blvd., Hon., HI 96817 or FAX 847-9836.

**Banner I.D. # or Birthdate**

_____	_____	_____
Last Name	First Name	M.I.
_____	_____, HI _____	_____
Mailing Address	City	Zip Code
_____	_____@_____	_____
Phone (please circle: home/work/cell)	Email address	

**? ACADEMIC ACCOMMODATIONS (Non-Elevator):**

**Accommodations are not guaranteed and are determined on an individualized basis after assessing documentation of disability and limitations.** A qualified professional may sign this document after appropriate testing/diagnosis is made. Adult educational testing (at age 17 or older) and any previous educational testing results should be attached.

Qualified Professional  
 M.D.  
 Certified Educational Psychologist,  
 Psychiatrist, Learning Disabilities Specialist  
 Psychologist or Psychiatrist

for Diagnosis/Condition  
 Physical limitations & ADD/ADHD  
 Learning Disabilities validated by educational testing  
 Psychological Disabilities

Diagnosis or Condition: \_\_\_\_\_

And this impacts the student's ability to: \_\_\_\_\_

\_\_\_\_\_.

**In my professional judgment, the most appropriate accommodations for this student are:**

Please mark the box (es) below and include the associated reason for the accommodation(s).

<b>Recommended Service:</b>	<b>Reason as it relates to condition:</b>	<b>SSD Approval</b>
<input type="checkbox"/> Notetaker	_____	_____
<input type="checkbox"/> Scribes	_____	_____
<input type="checkbox"/> Mobility Assistance	_____	_____
<input type="checkbox"/> Equipment Modification	_____	_____
<input type="checkbox"/> Sign Language Interpreter	_____	_____
<input type="checkbox"/> Materials in alternate format: taped books, enlargement	_____	_____
<input type="checkbox"/> Distraction-reduced Testing	_____	_____
<input type="checkbox"/> Extended Exam Time at _ 1 ½ times _ 2 times	_____	_____
<input type="checkbox"/> Other & Reason:	_____	_____

<b>EXAMINING PROFESSIONAL TO SIGN</b>
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As the examining professional with specialty in \_\_\_\_\_, I attest the above to be true.

X _____	_____	_____	_____
Physician's Signature	Title	Date	Official Stamp