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 making him or her eligible for disability-related services and is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Eligible conditions and the authorized health professionals who may verify them and sign the Disability Verification Form are described on the attached “Disability Definitions and Documentation,” page 4.

INSTRUCTIONS:
1. **Items 1–5 — These items 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 form must be completed and signed by the health professional qualified to diagnose and treat the specific condition. (See attached “Disability Definitions and Documentation.”)**
4. **Please return this form by mail, unless requested otherwise by the student.** (Attach any medical, psychological, and/or educational documentation.)
   
   Paul Mitchell The School Portsmouth
   
   Anne Sullivan
   
   140 Congress Street, Portsmouth, New Hampshire 03801

Please indicate any restrictions or other recommendations, if appropriate.

This completed form must be returned to the school’s Admissions Leader 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 admissions office at (603) 436-7775.

Sincerely,

Anne Sullivan
Paul Mitchell The School Portsmouth
Admissions Leader
INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Paul Mitchell The School Portsmouth, a student must submit a Disability Verification Form, documenting a physical and/or psychological disability. The 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 on the Disability Verification Form [page 3] either online before printing it or print the form and complete the section by hand.

☐ **STEP 2:** Print this packet, which includes four pages: Instructions, Form, Letter, and Disability Definitions.

☐ **STEP 3:** Provide this packet to your treating professional.
Disability Verification Form

STUDENT INFORMATION

Name: ____________________________________________  ID #: ____________________  Birthdate: _________________

Address: ____________________________________________  City: __________________________ Zip: _______________

Telephone Number: __________________  Cell Phone Number: _____________________ E-mail: _______________________

TO BE COMPLETED BY PROFESSIONAL

Name of Licensed or Certified Professional: _____________________________________________________________________

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 us determine 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 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. Condition is: ☐ Stable ☐ Prone to exacerbation

6. Duration of Disability: ☐ Permanent/Chronic ☐ Temporary
   If temporary, select one:
   ☐ 45 days or greater
   ☐ Less than 45 days
   Expected duration: ________________________

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on his or her written request.

Signature: ______________________________  Title/Lic. #: ___________________________  Date: _____________________

If the above information is completed by an individual other than the professional who made the diagnosis, please provide the name and the phone number of the person who filled out the form:

Name: _________________________________  Title: ________________________________  Phone: ____________________

TO BE COMPLETED BY PAUL MITCHELL SCHOOLS STAFF

☐ Assessment by appropriate staff
☐ Review of documentation by outside agency/certified/licensed professionals

P= Primary
S= Secondary Full Service (more than one secondary is possible)

ABI:_____ HEARING:_____ MOBILITY:_____ PSYCH:_____ VISION:_____ DDL:_____ LD:_____ OTHER:_____ SPEECH:_____ NONCLAIM:_____
**Physical Disability**  
Visual, mobility or orthopedic impairment  
Medical Doctor, O.D.

**Visual Impairment**  
Total or partial loss of sight: in best eye, with best correction, visual acuity 20/200=legal blindness or 20/70 =partial sight  
M.D, Ophthalmologist, Optometrist

**Mobility, Orthopedic Impairment**  
Serious limitation in locomotion or motor function  
M.D, O.D., see Comments  
D.C. 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, M.D.  
Submit: Disability Verification Form and audiogram within the last year

**Deaf**  
Requires use of communication mode other than oral, including sign language  
Audiologist, M.D.  
Submit: Disability Verification Form and audiogram within the last year

**Hard of Hearing**  
1. Severe=avg. loss in better ear, 55 db. 2. Mild-Moderate=avg. unaided loss in better ear 35–44db.; aided, 20–54 db. or greater 3. Speech discrimination less than 50% 4. Documentation of rapid loss  
Audiologist, M.D.  
Submit: Disability Verification Form and audiogram within the last 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 WJIV)  
PhD Psychologist, College LD Specialist, Other appropriate professional  
Submit 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  
M.D. 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 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.  
Not qualified: DSM V Codes, developmental disorders, sexual behavior disorders; compulsive gambling, kleptomania, or pyromania and psychoactive substance abuse disorders resulting from current illegal use

**ADD/ADHD**  
Meets DSM diagnostic criteria and poses an educational limitation  
Psychiatrist; PhD.  
Examples include, but are not limited to: heart conditions, renal failure, tuberculosis, AIDS, diabetes

**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
Request for Reasonable Accommodations

Name: _______________________________________________  __________________________
  Last   First   Middle Initial

Once you have completed the form, please provide it to either the School Director or Compliance Coordinator.

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

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

State the accommodation that you are requesting:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

List all possible alternative accommodations:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

Applicant Signature: _______________________________________________  Date: ________________

School Director Receipt of Request Date: ______________________________