CONFIDENTIAL

Paul Mitchell The School Jersey Shore
712 Route 70
Brick, NJ 08723
(732) 262-4900

Disability Verification Form

LETTER TO TREATING PROFESSIONAL

Date:

Dear Health Professional:

The patient named on the attached Paul Mitchell The School Jersey Shore **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 Jersey Shore
   Arianna Gomes
   712 Route 70, Brick, NJ 08723

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 (732) 262-4900.

Sincerely,

Arianna Gomes
Paul Mitchell The School Jersey Shore
Admissions Leader

Paul Mitchell The School Jersey Shore
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Disability Verification Form

INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Paul Mitchell The School Jersey Shore, 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.

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PAUL MITCHELL schools

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:____

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PAUL MITCHELL schools

Disability Verification Form

DISABILITY DEFINITIONS AND DOCUMENTATION

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.

Paul Mitchell The School Jersey Shore uses the information requested on the Disability Verification Form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services.

Disability	Community College Definition*	Qualified Professionals	Important Notes
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, 20/200=legal blindness or 20/70 =partial sight	M.D, Opthalmologist, 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 35–54db.; 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 WIAT II)	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. Psychologist, LMFT or LCSW (indicate license #)	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. Psychologist, LMFT or LCSW (indicate license #)	
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

For further information on qualifying disabilities and/or signature and documentation requirements, call (732) 262-4900.
Personal information recorded on this 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 being collected pursuant to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

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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: _____