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 Provo
Mark Farmer
480 North 900 East
Provo, Utah 84606

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 (801) 374-5111.

Sincerely,

Mark Farmer
Paul Mitchell The School Provo
Admissions Leader
INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Paul Mitchell The School Provo, 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)


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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, O.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 35–54 db.; 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
WJAT 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 (801) 374-5111.
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).
Request for Reasonable Accommodations

Name: _________________________________________________________________________________

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: ______________________________