CONFIDENTIAL

Bella Capelli Academy One
151 Wyngate Dr., Monroeville, PA, 15146
(412)-373-6311

PAUL MITCHELL schools

Disability Verification Form

LETTER TO TREATING PROFESSIONAL

[INSERT DATE]

Dear Health Professional:

The patient named on the attached Bella Capelli Academy One **Disability Verification Form** has requested that his or her disability be verified. This documentation is for the purpose of qualifying him or her as eligible for disability-related services and is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

Locate the eligible conditions and the authorized health professionals who may verify them and sign the Disability Verification Form on the attached Disability Definitions and Documentation, page 4.

INSTRUCTIONS:

1. **Items 1–5 — These items on the Disability Verification Form 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 Disability Verification Form must be ***completed* and *signed* by the health professional** qualified to diagnose and treat the specific condition. *(Refer to the attached Disability Definitions and Documentation.)*
4. **Please return the Disability Verification Form by mail,** unless requested otherwise by the student. *(Attach any medical, psychological, and/or educational documentation.)*

Bella Capelli Academy One
Danielle Shiffler
151 Wyngate Dr., Monroeville, PA, 15146

Please indicate any restrictions or other recommendations, if appropriate.

The completed Disability Verification Form must be returned to the school's ADA coordinator 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 ADA coordinator at (412)-373-6311 .

Sincerely,

Danielle Shiffler
Bella Capelli Academy One

ADA Coordinator

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Disability Verification Form

INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Bella Capelli Academy One , a student must submit the Disability Verification Form documenting a physical and/or psychological disability. The Disability Verification 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 of the Disability Verification Form, page 3, either online prior to printing ***or*** print the Disability Verification Form and complete the section by hand.
- ☐ **STEP 2:** Print this material *(four pages)*, which includes the letter, the instructions, the form, and the disability definitions.
- ☐ **STEP 3:** Provide this material to your treating professional.

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Disability Verification Form

STUDENT INFORMATION

Name: _____ ID Number:_____ Birthdate: _____
Address: _____ City:_____ Zip: _____
Telephone Number:_____ Cell Phone Number: _____ E-mail:_____

TO BE COMPLETED BY LICENSED OR CERTIFIED PROFESSIONAL

Licensed or Certified Professional Name: _____
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 determine the 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 one's 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. The condition is: ☐ Stable ☐ Prone to exacerbation

6. Duration of disability: ☐ Permanent/chronic ☐ Temporary

If temporary, select one:
☐ 45 days or more
☐ Less than 45 days
Expected duration: _____

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

Signature: _____ Title/License Number: _____ Date: _____

If the above information is completed by an individual other than the professional who made the diagnosis, please provide the name and the telephone number of the individual who completed the Disability Verification Form:

Name: _____ Title:_____ Telephone: _____

TO BE COMPLETED BY PAUL MITCHELL SCHOOLS STAFF

☐ Assessment by the appropriate staff
☐ Documentation review 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: ❶ fall within the diagnostic categories listed below; **and** ❷ impair a major life activity; **and** ❸ pose an educational limitation for which accommodation is required and appropriate.

Bella Capelli Academy One *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	MD, OD	
Visual Impairment	Total or partial loss of sight: in best eye, with best correction, 20/200=legal blindness or 20/70 =partial sight	MD, ophthalmologist, optometrist	
Mobility, Orthopedic Impairment	Serious limitation in locomotion or motor function	M.D, O.D., see comments	DC 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, MD	Submit the Disability Verification Form and audiogram within the past year
Deaf	Requires use of communication mode other than oral, including sign language	Audiologist , MD	Submit the Disability Verification Form and audiogram within the past 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 percent 4. Documentation of rapid loss	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past 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 learning disability specialist, other appropriate professional	Submit the 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	MD 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 the 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 number)	Not qualified: DSM V codes, developmental disorders, sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance abuse disorders resulting from current illegal use
ADD/ADHD	Meets the DSM diagnostic criteria and poses an educational limitation	Psychiatrist; PhD psychologist, LMFT or LCSW (indicate license number)	
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, contact the school's ADA coordinator at (412)-373-6311 **.** Personal information recorded on the Disability Verification 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 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 Disability Verification Form, submit it to the School Director or ADA coordinator.

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

_____

_____

_____

_____

State the accommodation requested:

_____

_____

_____

_____

List all possible alternative accommodations:

_____

_____

_____

_____

Applicant Signature:_____ Date: _____

Receipt of request date: _____

(The School Director or ADA coordinator must complete the request date.)

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