Bucks County Community College

Verification Form

Deaf and Hard of Hearing

Bucks County Community College's Accessibility Office (TAO) has established the Verification Form for Deaf and Hard of Hearing to obtain current information from a qualified practitioner (e.g., audiologist, otolaryngologist (ear, nose, and throat physician), otologist) regarding a student's hearing impairment and its impact on the student and his or her need for accommodations. This Verification Form may supplement information that is provided in other reports, including audiograms, medical reports, or secondary school documentation. Any documentation, including this Verification Form, must meet Bucks County Community College's TAO guidelines for Deaf and Hard of Hearing conditions. **The person completing this form may not be a relative of the student or hold power of attorney over the student.**

A summary of the guideline criteria for documenting hearing impairments can be found at the following web site: http://www.bucks.edu/student/accessibility/student-info/. A summary of the guideline criteria for documenting Deaf and Hard of Hearing is as follows:

1. Evidence of current deaf and hard of hearing impairment
2. Functional impairment affecting an important life skill, including academic functioning
3. History of use of hearing devices or assistive technology related to deaf and hard of hearing impairment
4. Summary and recommendations

Section I: Student Information (Please type information or print legibly)

Student Name: _____
Last First Middle

Student ID: _____ **Date of Birth:** _____

Cell Phone: _____ **Home Phone:** _____

Bucks Email: _____ **Home Email:** _____

Permanent Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Local Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Section II: Provider Section (Please type information or print legibly)

A. Contact with the Student:

Date of initial contact with the student: _____

Date of last contact with the student: _____

Frequency of appointments with student (e.g., once a week, once a month)**:** _____

B. Diagnosis Information:

1. What is the student's diagnosis?

Newtown Campus • Student Services Center • Rollins Building • 275 Swamp Road • Newtown • PA • 18940
(215) 968-8182 • (215) 968-8033 fax • accessibility@bucks.edu • http://www.bucks.edu/student/accessibility/

2. When was the student diagnosed with the condition?

Month _____ Year _____

3. What is the severity of the impairment? ☐ Mild ☐ Moderate ☐ Severe

a. Explain the severity checked above:

4. What is the expected duration of the impairment?

Short-term (<6 months):	☐	Long-term (>6 months-1 year):	☐
Episodic:	☐	Chronic (>1 year with frequent recurrence):	☐

c. Explain the duration checked above:

5. Current Symptoms:

a. What is the student's current loss of hearing as determined by an audiological assessment?

b. What is the date(s) of the student's most current audiological assessment? Please attach a copy of the most recent audiogram.

c. Is the hearing loss expected to remain stable or is it expected to decline? If it is expected to decline, please describe the expected progression of the hearing loss.

d. Is there clear evidence that the symptoms associated with the hearing impairment are interfering with or reducing the quality of at least one of the following, including academic functioning?

Environmental Functioning:	
School functioning:	
Social functioning:	
Work functioning:	
Language functioning:	

C. Student's History:

1. **Please include any historical information relevant to the student's hearing impairment and associated functioning** (e.g., developmental, familial, medical, pharmacological, psychological, psychosocial)**.**

2. **Assistive Technology (AT):**
   a. Are hearing aids, FM systems, or other devices prescribed to assist the student's hearing? If so, what is the student's hearing threshold with the hearing aids, FM systems, or other hearing devices?

   b. Does the student have a cochlear implant(s)? If so, when did the student get the cochlear implant(s) and which ear(s) is the implant located (left or right)? What is the student's hearing threshold with the cochlear implant(s)?

   c. If the student currently uses assistive or adaptive technologies related to his or her hearing impairment, please list specifics about the technology. What is the brand and model number for the student's hearing aids and/or cochlear implant? If the student needs an FM system or other hearing device in the classroom, what FM system or recommended hearing device would be compatible with the student's hearing aids or cochlear implant?

d. What is the student's preferred mode of accessing in-class lectures and materials (e.g., American Sign Language, Signed English, Real Time Captioning)?

3. **ICD-10-CM Diagnosis Codes:** Please include all pertinent diagnoses or rule-out diagnoses using ICD-10-CM codes.

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D. Medications:

1. Is the student currently taking medication(s) for any symptoms related to the diagnosis? ☐ **Yes** ☐ **NO**
2. If yes, please provide information below for each medication the student is currently prescribed:

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

Medication • Dosage • Frequency (e.g., Adderall 5 mg 1 x daily):	
Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

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Date Prescribed:	
Side effects that impact the student's functioning (e.g., concentration, sleep, thinking, eating, etc.):	

D. Functional Limitations and Recommended Accommodations:

1. Please list the student's current hearing loss symptoms and then indicate what reasonable academic accommodations would mitigate the symptom listed.

2. **Sample:** Due to hearing impairment, the student cannot hear videos during class.

Symptom: (Example)
The student's impairment provides an inability to hear electronic voices.
Recommended Reasonable Accommodation(s):
Captioned Videos should be used in the classroom for the student to participate.

Symptom:
Recommended Reasonable Accommodation(s):

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Symptom:
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Symptom:
Recommended Reasonable Accommodation(s):

Section III: Provider's Certifying Professional Information:

(Please type information or print legibly)

Professionals conducting the assessment, rendering a diagnosis, and providing recommendations for reasonable accommodations must be qualified to do so (i.e., audiologist, otolaryngologist [ear, nose, and throat physician], otologist). The provider signing this form must be the same person answering the above questions.

Provider's Name: _____
Last First Middle

Credentials: _____

License Number: _____ **State of Licenser:** _____

Phone Number: _____ **Email:** _____

Practice Street Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

May this completed Verification Form be released to the student? ☐ **Yes** ☐ **NO**

Provider Signature: _____ **Date:** _____

Section IV: Submitting this Form

This form should be returned to the Accessibility Office (TAO) at Bucks County Community College where the student is enrolled. All forms need to be submitted at the Newtown campus. Please see the following methods of submission of this form:

Email: accessibility@bucks.edu

Fax: (215) 968-8033

USPS: Bucks County Community College
Attention: The Accessibility Office
275 Swamp Road
Newtown, Pennsylvania 18940

Physical Drop Off: Newtown Campus
Rollins Center • Student Services Office • Room 001

Information regarding the Accessibility Office (TAO) at Bucks County Community College can be found at http://www.bucks.edu/student/accessibility/. Please visit our website for the latest information and updates as they are made available. If you have any questions, please feel free to call us (215) 968-8182.