

## Verification Form: Hearing Impairments

Rev. 01.15.2025

Albright College's Student Accessibility and Advocacy (SAA) office has established verification forms to assist in obtaining current information from a qualified professional (e.g., medical physician, neurologist/neuropsychologist, clinical psychologist, licensed counselor, or other relevant provider) regarding a student's condition and symptoms. This form should be filled out by a licensed professional treating this individual for at least three months. To assist the student, we need to understand the student's symptoms, relevant medications and their impact on the student, and the student's need for accommodations. This verification form may supplement information provided in other reports, including medical reports or secondary school documentation. It is not a replacement for a full evaluation or test scores.

Any documentation must meet Albright College's documentation standards for the student's condition. A summary of the criteria for documenting a disability is listed below. Complete information can be found in the Albright College's Documentation Standards which is provided to the student. If you would like a copy of the standards, please call our office.

- Documentation must show evidence of a disability as defined by the ADA.
- Documentation must be no more than 3 years old except in rare circumstances.
- Documentation must describe functional impairment affecting an important life skill and how this affects the student in the college environment.
- Documentation must provide history relevant to the student's disability, including treatments, assistive devices, or other pertinent information.
- Documentation must establish a clear link between the recommended accommodation and the student's functional limitations.
- Documentation must present a summary and recommendations.

(Please **print legibly** or **type**; illegible documents will not be processed)

## Student Information

Student's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Home Address: \_\_\_\_\_

Local Address (if different): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

## Provider Section

Date of Initial Contact with Student: \_\_\_\_\_

Date of Most Recent Contact with Student: \_\_\_\_\_

## Diagnosis

What is the student's primary diagnosis? \_\_\_\_\_ ICD-11: \_\_\_\_\_

Descriptive features: \_\_\_\_\_

When was the student first diagnosed with this condition? \_\_\_\_\_

How long have you been treating the student for THIS condition? \_\_\_\_\_

How often is the student seen for THIS condition (e.g. weekly, monthly)? \_\_\_\_\_

What is the severity of the impairment?  Mild  Moderate  Severe

Explain how you determined the severity indicated above?

\_\_\_\_\_  
\_\_\_\_\_

How was this student diagnosed/what diagnostic tools or tests were used? (please submit results with this form)

\_\_\_\_\_  
\_\_\_\_\_

Do you consider this student to have a disability?  Yes  No

*(Please print legibly or type; illegible documents will not be processed)*

## Current Symptoms

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

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What is the date of the student's most recent audiological assessment? \_\_\_\_\_

(please submit a copy of the most recent audiogram)

Is the student's hearing expected to remain stable or expected to decline?

Expected to remain stable

Expected to decline

If expected to decline, please describe how you anticipate hearing loss to progress:

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What is the expected duration of the impairment?

Short term (less than six months)

Episodic

Long-term (six months to one year)

Chronic (more than one year)

Please explain why the above duration was chosen:

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*(Please print legibly or type; illegible documents will not be processed)*

**Current Symptoms (cont'd)**

Is there clear evidence that the symptoms associated with the student's diagnosis are interfering with or reducing the quality of at least one of the following within the academic environment?  No  Yes

If yes, please explain in the space provided.

Academic functioning:

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Social functioning:

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Workplace functioning:

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Is there any other historical information related to the student's impairment that you feel is necessary or helpful to consider (e.g., medical, psychological, developmental)?

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*(Please print legibly or type; illegible documents will not be processed)*

**Functional Limitations and Recommended Accommodations**

It is important for us to understand how the student’s current symptoms cause functional impairments in a college environment. Accommodations are not based on the student’s diagnosis or medication, but rather on the limitations of their functioning in the educational environment. Based on your knowledge of the student, please provide information regarding reasonable academic accommodations and the rationale for each accommodation based on the student’s symptoms.

Symptom: \_\_\_\_\_

How does this affect the student?

\_\_\_\_\_  
\_\_\_\_\_

Recommended reasonable accommodation:

\_\_\_\_\_

Symptom: \_\_\_\_\_

How does this affect the student?

\_\_\_\_\_  
\_\_\_\_\_

Recommended reasonable accommodation:

\_\_\_\_\_

Symptom: \_\_\_\_\_

How does this affect the student?

\_\_\_\_\_  
\_\_\_\_\_

Recommended reasonable accommodation:

\_\_\_\_\_

Please **print legibly** or **type**; illegible documents will not be processed)

## Assistive or Adaptive Technology

What is the student's preferred mode of accessing in-class lectures and other materials (e.g., ASL, real-time captioning)?

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Does the student currently use hearing aids, FM systems, or other devices prescribed to assist the student's hearing?  No  Yes

If yes, please describe the device(s) used and the student's hearing threshold with the device(s):

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Does the student have cochlear implants?  No  Yes

If yes, please describe the student's hearing threshold with the cochlear implant(s):

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Is the student using other assistive/adaptive technologies related to their hearing impairment?  No  Yes

If yes, please describe in detail what technology is being used:

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If assistive technologies are currently being used in collaboration with hearing aids or implants, please list the brand and model number of the hearing aid(s) or implant(s):

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Please **print legibly** or **type**; illegible documents will not be processed)

## Provider's Certifying Information

Professionals rendering assessments and diagnoses and providing recommendations for reasonable accommodations must be relevant and qualified to do so (e.g., medical doctor, neurologist/neuropsychologist, psychologist, licensed counselor). The provider signing this form **MUST** be the same person who answered the questions above, and **MAY NOT** be related to the student.

Provider's Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Provider's Name (printed): \_\_\_\_\_

Credentials: \_\_\_\_\_

License Number: \_\_\_\_\_

State of Licensor: \_\_\_\_\_

Office or Business Name: \_\_\_\_\_

Office or Business Address: \_\_\_\_\_

Office Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

## Directions for Submitting this Form and Supporting Documentation

This form is not a substitute for evaluation or testing data. Please submit this form, along with the student's most current evaluation, test results/scores, and other supporting documents directly to the SAA office. Documentation can be faxed to us at (610) 929-6793 or mailed to us at:

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