Ocean County College
Office of Disability Services
Building 3, Library Room 016
Phone: 732.255.0456
Email: accommodations@ocean.edu

Documentation Form

Autism / Autism Spectrum Disorder (ASD) / Asperger's Syndrome

This form is to be completed in its entirety by a qualified professional such as a psychologist, neuropsychologist, neurologist, or psychiatrist.

Student's Name:_____ **OCC ID:**_____

The student named above is applying for disability accommodations and / or services through the Office of Disability Services ("Disability Services") at Ocean County College (OCC). To determine eligibility, a qualified professional must certify that the student has been diagnosed with Autism / Autism Spectrum Disorder (ASD) / Asperger's Syndrome and provided evidence that it represents a substantial impediment to a major life activity. It is important to understand that a diagnosis of Autism / Autism Spectrum Disorder (ASD) / Asperger's Syndrome in itself does not substantiate a disability. In other words, information sufficient to render a diagnosis might not be adequate to determine that an individual is substantially impaired in a major life activity. This documentation form was developed as an alternative to traditional diagnostic reports. If a traditional diagnostic report is being submitted as documentation instead of this form, please refer to the Disability Services website (go.ocean.edu/DS) in order to view documentation guidelines. Disability Services expects the following regarding this documentation form:

- The form will be completed with as much detail as possible as partially completed form or limited responses may hinder the eligibility process.
- The diagnosis of Autism / Autism Spectrum Disorder (ASD) / Asperger's Syndrome was derived through multiple assessment instruments that included formal measures.
- The assessment information is not more than three years old.
- The form is being completed by a professional qualified by having had comprehensive training and direct experience in the differential diagnosis of Autism / Autism Spectrum Disorder (ASD) / Asperger's Syndrome such as a psychologist, neuropsychologist, neurologist or psychiatrist.
- The professional completing the form is not a family member of the student or someone who has a personal or business relationship with the student.

Please respond to the following items regarding the student named above (type or print):

What is the DSM-V diagnosis for this student?_____

_____

Date(s) current assessment completed:_____

Date of last contact with student:_____

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

How long has the student had this diagnosis/condition?_____

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Psychological History: Provide pertinent psychological history (include any psychological reports or testing utilized, if applicable):_____

_____

_____

_____

_____

Does the student have a disability* as a result of their condition that warrants accommodations (check one)? ☐ Yes ☐ No

**The ADA defines a person with a disability as a person who has a physical or mental impairment that substantially limits one or more major life activity.*

Student's primary current symptom(s) and concern(s):_____

_____

_____

_____

What is the severity of the symptom(s) (check one): ☐Mild ☐Moderate ☐Severe

Explain the severity indicated above:_____

_____

_____

_____

Psychosocial History: Provide pertinent information obtained from the student/ parent(s)/guardian(s) regarding the student's psychosocial history (e.g., history of not sustaining relationships, history of employment difficulties, history of educational difficulties, social inappropriateness, history of risk-taking or dangerous activities, etc.):_____

_____

_____

_____

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Explain how the symptoms related to the student's disorder cause <u>significant impairment in a major life activity</u> (e.g., learning, eating, walking, interacting with others, etc.) in a classroom setting, if applicable:

_____

_____

_____

In the event of an on-campus emergency requiring evacuation (e.g. fire drill, bomb threat), will this student need assistance (check one): ☐ Yes ☐ No

If Yes, please explain: _____

_____

_____

_____

Explain how the symptoms related to the student's disorder cause <u>significant impairment in a major life activity</u> (e.g., learning, eating, walking, interacting with others, etc.) in a classroom setting, if applicable:

_____

_____

_____

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Provide specific information about the academic limitations and severity of symptoms this student encounters as a result of Autism / ASD / Asperger's Syndrome by placing an "X" in the appropriate box.

Activity	No Limitation	Moderate Limitation	Substantial Limitation	Don't Know
Attention to detail / accuracy of work				
Sustaining attention				
Listening comprehension				
Completing tasks independently				
Sustained mental effort				
Organization				
Distractibility				
Memory				
Restlessness				
Impulsiveness				
Time management				
Mathematics				
Reading				
Writing				
Other (please specify)				

What above symptoms impact the student the most? In which settings is the student impacted the most?_____

_____

_____

State the student's functional limitations from the disorder specifically to the college setting:_____

_____

_____

_____

State recommendations regarding academic adjustments or accommodations, aids, and/or services for this student and the reason these accommodations are warranted based upon the student's functional limitations:_____

_____

_____

_____

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Pharmacological History: Provide pertinent pharmacological history. List the student's current medication(s), dosage, frequency, and adverse side effects:_____

_____

_____

_____

_____

☐ **Not applicable, student is not taking medication for the above-mentioned condition(s).**

Are there significant limitations to the student's functioning directly related to the prescribed medications (check one)? ☐ Yes ☐ No ☐ Not applicable

If yes, explain:_____

_____

_____

_____

Provide an explanation of the extent to which the medication <u>currently mitigates</u> the symptoms of the disorder:_____

_____

_____

_____

If current treatments (e.g., medications, counseling) are successful, state the reasons the above academic adjustments and/or accommodations, auxiliary aids, and/or services are necessary:_____

_____

_____

_____

_____

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Certifying Professional

All areas below must be completed by the certifying professional such as a psychologist, neuropsychologist, psychiatrist or other relevantly trained medical doctor.

Name and Title:_____

License or Certification #:_____

Company/Office/Institution/Affiliation Name:_____

Address:_____

City, State, Zip:_____

Phone #:_____Fax #:_____

Email Address:_____

Signature of
Certifying Professional:_____Date:_____

Official Company/Office/Institution/Affiliation Stamp (stamp below)

Documentation Retention

All submitted materials will be held with OCC Disability Services as confidential educational records under the Family Educational Rights and Privacy Act (FERPA). Students have a right to review their educational record. However, students are encouraged to retain their own copies of disability documentation for future use as the college is not obligated to produce copies for students. Under current New Jersey record retention requirements, disability documentation is mandated to be held for only two years after a student has stopped attending the college.

Methods of return to OCC Disability Services:

- Print, scan and upload via the secure student Accommodate portal (online)
- Print, scan and upload to general office portal go.ocean.edu/upload
- Print and fax to 732-864-3860
- Print and scan to accommodations@ocean.edu