COUNTY COLLEGE OF MORRIS

ACCESSIBILITY SERVICES

Disability Verification Form

Student Applicant Information

Student Name: _____ **Student ID:** _____

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

Phone Number: _____ **Email:** _____@student.ccm.edu

FOR PROVIDER USE ONLY:

Date: _____

Disability Diagnosis:

Current Treatment (if any):

Impact of Disability in Academic Settings:

Recommended Accommodations:

PLEASE COMPLETE REVERSE SIDE OF FORM →

Provider Information:

Provider Name: _____License #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Please return the completed form to ASO@ccm.edu as soon as possible so that we can determine the student's accommodation eligibility.