Disability Disclosure Form – Hearing Loss

Date: __________________________

Dear (Clinician Name) ____________________________________________:

I am requesting services from the Disability Resource Center (DRC) at Northeastern University. In order to receive services, the DRC requires documentation of my disability. Services at the DRC are solely based on diagnostic documentation. Once this information is in place, it will be used to develop a service plan for me.

☐ I hereby authorize you to complete the enclosed Disclosure Form and release it to the DRC.

☐ I authorize you to attach a copy of my current audiology report, as requested.

☐ I also authorize you to speak with my DRC Specialist in consultation to provide future services.

Please submit the completed form to:

Ms. Debbi Auerbach, Service Coordinator

By mail:
Northeastern University
Disability Resource Center
20 Dodge Hall
Boston, MA 02115

By confidential fax: 617-373-7800

You may contact Ms. Auerbach with any questions (phone: 617-373-2675 / TTY: 617-373-2730 or email: d.auerbach@neu.edu).

Thank you for your timely assistance with this matter.

Sincerely,

__________________________________________  ______________________________
Student Signature                           Date

__________________________________________  ______________________________
Print Name                                  Medical Record ID#

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This form must be completed by the licensed clinician or health care provider who is treating this patient for the diagnosis identified in this document. Please attach the most recent evaluation(s) and a copy of a current audiology report.

Patient’s/Client’s Name: __________________________________________

Clinician’s Name: ________________________________________________

Clinician’s State Licensure/ Certification #: __________________________

Area of Specialty: ____________________________ Clinician’s phone #: ____________

The person named on this form is requesting services from the Disability Resource Center. The DRC offers services to students who are considered disabled under the mandates of the Americans with Disabilities Act of 1990 (ADA). Under the ADA definition, a person with a disability is one with a physical, mental, emotional or chronic health impairment that substantially limits one or more major life activity such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. Major life activities also include bodily functions relating to the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproduction (this is not an exhaustive list).

I verify that the person named in this document has a substantially limiting disorder that meets the aforementioned ADA disability criteria:  Yes ☐  No ☐

If yes, please thoroughly complete this form to document the substantial limitations that are linked to this disability.

▪ Diagnosis/Description of Disability: __________________________________________

▪ Please provide full DSM or ICD-9 code: __________________________________________

▪ Initial Date of Diagnosis: _______________  ▪ Date of last clinical contact: __________

▪ Expected duration of disability noted above is:
  □ Permanent  □ Short term (60-90 days)
  □ Chronic  □ Temporary (1-60 days)
  □ Long term (3-12 months)

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- Level of hearing loss is:  □ Mild  □ Moderate  □ Severe  □ Profound

- **Assessment Instruments and Results** (Please describe the procedures, assessment tools, etc. used to establish the diagnosis):

- Please describe the functional impact of the disability/symptoms on this individual’s:
  □ Daily life (include any limitations related to personal care, social interactions, manual tasks, etc.)

  □ Academic environment  (note: please consider situations in and out of the classroom)
Please comment on the following items as applicable:

- If Deaf-Blind, rate Mobility and Orientation (travel skills):  **Novice**  **Intermediate**  **Advanced**  
  *(Please include current vision evaluation report; see Disclosure Form for Blind/Vision Impairment)*

- Communication method (indicate all that are used):

  - American Sign Language
  - Signed English (PSE)
  - Other Signed Language (e.g. Spanish)
  - Cued Speech
  - Oral: English. Other Language:______________
  - Tactile Sign Language
  - Close Vision Signing
  - Other: ______________________________

- This person uses any or all of the following (indicate specific device or service):

  - Hearing Aids
    - Bilateral
    - Unilateral
    - (type/model: ________________________________)
  - Cochlear Implant. Type:______________
    - Month/Year of surgery: __________
    - Month/Year of most recent map: __________
  - Service Animal (Hearing Dog)
  - Assistive Listening Device
    - (please specify: ________________________________)
  - Other Technology/Aids
    - (please specify: ________________________________)

- Suggested accommodation(s) for the academic setting:

  - Alternate Text Formats (Deaf-Blind)
  - Assistive Listening Device
  - Captioned Media
  - Housing (circle any that apply)
    - Signaling: Visual and/or Vibration
    - Service Animal Relief Area
    - Other: ______________________________
  - Note-taking
  - Oral Transliteration
  - Preferential Seating
  - Sign Language Interpreting/Transliterating
  - Speech to Text Services
  - Other: ______________________________

- Additional information:

  *NOTE: Please attach a current Audiology Report to this Disclosure Form*

  ____________________________  __________________________
  Clinician/Professional Signature  Date

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