THE TEMPLE ANNAPOLIS PAUL MITCHELL PARTNER SCHOOL

INSTRUCTIONS TO FUTURE PROFESSIONAL

In order for **THE TEMPLE Annapolis: A Paul Mitchell Partner School** to evaluate your request for accommodation(s), please provide us with documentation from your healthcare professional(s) substantiating your physical or mental impairment(s), how that impairment, or impairments, limits a "major life activity", and addressing how the requested accommodation will ameliorate the limitations of those impairment(s).

For your convenience, we are enclosing our template **Disability Verification Form**. You may have your healthcare professional utilize this in lieu of their own documentation. It must be completed in full by them following the instructions on the form. A hard copy must them be signed by your healthcare professional and returned to us.

You are not required to use this form.

Upon receipt of the required documentation, whether it is our **Disability Verification Form**, or some other approved documentation, we will promptly evaluate your request.

- **STEP 01:** Complete the Student Information section of the **Disability Verification Form** (PAGE 03), either online prior to printing OR by first printing out the **Disability Verification Form** then completing this section by hand.

- **STEP 02:** Print the remaining material (all four pages), which includes the **Letter to Treating Professionals,** the **Instructions to Future Professionals**, the **Disability Verification Form**, and the **Disability Definitions and Documentation**.

- **STEP 03:** Provide all four pages to your treating health care professional.

- **STEP 04:** Once your healthcare professional has successfully completed AND SIGNED the **Disability Verification Form** and supplied any required supporting documentation, you will fill out the **Request for Reasonable Accommodation** and sign it.

- **STEP 05:** You will then combine all five pages and turn them in to our ADA Coordinator.

Jolene Johnson
ADA Coordinator
jolenej@templeannapolis.com
443-782-3018

THE TEMPLE ANNAPOLIS PAUL MITCHELL PARTNER SCHOOL

LETTER TO TREATING PROFESSIONAL

Dear Healthcare Professional:

The individual listed on the attached **THE TEMPLE Annapolis: A Paul Mitchell Partner School Disability Verification Form** has requested accommodation(s) for his/her physical or mental impairment(s). To help us evaluate the requested accommodation, we ask that you complete the enclosed Disability Verification Form.

"**Eligible Conditions**" and the type of "**Authorized Health Professionals**" who may verify them and sign the **Disability Verification Form** are defined on PAGE 04: Disability Definition and Documentation

INSTRUCTIONS

1. **Items 1–6: These items on the Disability Verification Form must be completed.**
2. **Item 2: At least one "major life activity"** limitation must be checked in order for the student to be eligible.
3. The Disability Verification Form must be ***completed*** **and** ***signed*** **by the health professional** qualified to diagnose and treat the specific condition. *(Refer to the attached Disability Definitions and Documentation.)*
4. **Please return the Disability Verification Form by mail,** unless requested otherwise by the student. *(Attach any medical, psychological, and/or educational documentation.)*

THE TEMPLE Annapolis: A Paul Mitchell Partner School
ATTN: Jolene Johnson
2303 Forest Drive, Suite C
Annapolis, MD 21401

Please indicate any restrictions or other recommendations, if appropriate.

The completed Disability Verification Form must be returned to the school's ADA coordinator before the student can receive disability-based accommodations.

Thank you for your prompt attention on behalf of your patient. If you have questions, please call our school's ADA coordinator at **443-782-3018.**

Sincerely,

Jolene Johnson
ADA Coordinator
jolenej@templeannapolis.com
443-782-3018

ADA Coordinator

THE TEMPLE ANNAPOLIS PAUL MITCHELL PARTNER SCHOOL

CONFIDENTIAL

Disability Verification Form

STUDENT INFORMATION

Name: _____ ID Number:_____ Birthdate: _____

Address: _____ City:_____ Zip: _____

Personal Phone Number: _____ E-mail:_____

TO BE COMPLETED BY LICENSED OR CERTIFIED PROFESSIONAL

Licensed or Certified Professional Name: _____

Address: _____ City:_____ Zip: _____

Telephone Number: _____ E-mail:_____

Please provide the following information in full in order to qualify the student for eligibility and help determine the reasonable educational and physical accommodations:

1. What is the nature of his/her physical or mental impairment(s):

_____

_____

2. This condition substantially limits the following major life activities: **(This section is required)**

☐ Moving ☐ Walking ☐ Manual tasks ☐ Bending ☐ Standing ☐ Lifting ☐ Breathing ☐ Concentrating
☐ Seeing ☐ Reading ☐ Hearing ☐ Communicating ☐ Sleeping ☐ Eating ☐ Caring for one's self

3. How will his/her physical and/or mental impairment(s) substantially impact his/her major life activities?

_____

_____

4. What, if any, accommodations do you recommend be provided to help ensure his/her equal access and/or full opportunity to participate in our education program? For each recommendation, please explain how that accommodation will ameliorate a substantial limitation:

_____

_____

5. The condition is: ☐ Stable ☐ Prone to exacerbation

6. Duration of disability: ☐ Permanent/chronic ☐ Temporary ... SELECT ONE: ☐ 45 days or more ☐ Less than 45 days
Expected duration: _____

I understand that the information provided will become part of the student record subject to the federal Family Educational Rights and Privacy Act of 1974 and may be released to the student on his or her written request.

Signature: _____

Title/License Number: _____ **Date:** _____

If the above information is completed by an individual other than the professional who made the diagnosis, please provide the name and the telephone number of the individual who completed the Disability Verification Form:

Signature: _____

Title/License Number: _____ **Date:** _____

THE TEMPLE ANNAPOLIS PAUL MITCHELL PARTNER SCHOOL

Disability Verification Form

DISABILITY DEFINITIONS AND DOCUMENTATION

Supporting medical documentation for individuals requesting reasonable accommodation(s) should specifify that a student has a physical or mental impairment and how that impairment substantially limits one or more major life activities.

In general, supporting medical documatnion must be dated less than three years from the date a student requests a reasonable accomodation, and must be cmopleted by a qualified professional in the area of the student's disability, as enumerated below:

Disability	Definition	Qualified Professionals	Important Notes
Physical Disability	Visual, mobility, or orthopedic impairment	MD, OD	
Visual Impairment	Total or partial loss of sight: in best eye, with best correction, 20/200=legal blindness or 20/70 =partial sight	MD, ophthalmologist, optometrist	
Mobility, Orthopedic Impairment	Serious limitation in locomotion or motor function	M.D, O.D., see comments	DC accepted for disabilities related to the back
Hearing Impairment: GENERAL	Loss of hearing, which impedes the communication process essential to language, educational, social, and/or cultural interactions	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past year
Hearing Impairment: DEAF	Requires use of communication mode other than oral, including sign language	Audiologist , MD	Submit the Disability Verification Form and audiogram within the past year
Hearing Impairment: HARD OF HEARING	1. Severe=avg. loss in better ear, 55 db. 2. Mild-Moderate=avg. unaided loss in better ear 35–54 db.; aided, 20–54 db. or greater 3. Speech discrimination less than 50 percent 4. Documentation of rapid loss	Audiologist, MD	Submit the Disability Verification Form and audiogram within the past year
Speech and Language Impairment	Speech/language disorders of voice, articulation, rhythm, and/or the receptive and expressive language processes	Licensed speech professional	***NOT*** caused by acquired brain injury, physical, psychological, or hearing impairments
Learning Disabilities	Cognitive ability test standard scores (usually WAIS III or WJ III), achievement test standard scores (usually the WJ III or the WIAT II)	PhD psychologist, college learning disability specialist, other appropriate professional	Submit the verification documents from the past year
Acquired Brain Impairment	Deficit in brain functioning caused by external or internal trauma, resulting in loss of cognitive, communicative, motor, psychosocial, and/or sensory-perceptual abilities	MD neurologist, neuropsychologist	Submit recent neuropsych report, if available; not applicable: conditions induced or present at birth, or progressive and/or degenerative in nature
Developmentally Delayed Learner	A DDL student is one who exhibits the following: a) below average intellectual functioning; and b) potential for measurable achievement in the instructional setting	Submit test results or regional center certification	Submit the verification documents from the past year
Psychological Disability	Persistent psychological or psychiatric disorder, or emotional or mental illness, moderate or severe on Axis I or II in the DSM, interferes with a major life function, poses an educational limitation	Psychiatrist; PhD psychologist, LMFT or LCSW (indicate license number)	Not qualified: DSM V codes, developmental disorders, sexual behavior disorders, compulsive gambling, kleptomania, pyromania, and psychoactive substance abuse disorders resulting from current illegal use
ADD/ADHD	Meets the DSM diagnostic criteria and poses an educational limitation	Psychiatrist; PhD psychologist, LMFT or LCSW (indicate license number)	
Other Disabilities	Health conditions that limit a major life activity, present an educational limitation, and require support services or instruction	Licensed certified professional who is legally qualified to diagnose the disability in question	Examples include, but are not limited to: heart conditions, renal failure, tuberculosis, AIDS, diabetes

For further information on qualifying disabilities and/or signature and documentation requirements, contact the school's ADA coordinator, Jolene Johnson at 443-782-3018. Personal information recorded on the Disability Verification Form will be kept confidential in order to protect against unauthorized disclosure. Portions may be shared with Paul Mitchell Schools or other state or federal agencies, in such a manner as to comply with applicable statutes regarding confidentiality, including the Family Educational Rights & Privacy Act (20 U.S.C. 1232(g) pursuant to Sect. 7 of the Federal Privacy Act (P.L. 93-578, 5 U.S.C. 552a, note). The information is collected pursuant to Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

CONFIDENTIAL

THE TEMPLE ANNAPOLIS PAUL MITCHELL. PARTNER SCHOOL

Request for Reasonable Accommodations

THIS FORM MUST BE COMPLETED BY THE REQUESTING INDIVIDUAL

REQUSTING INDIVIDUAL INFORMATION

Name: _____ ID Number:_____ Birthdate: _____

Address: _____ City:_____ Zip: _____

Personal Phone Number: _____ E-mail:_____

Identify the nature of your physical and/or mental impairment(s) for which you are requesting accommodations:

_____

_____

_____

Identify how your physical and/or mental impairment(s) will affect your ability to satisfy the School's requirement(s):

_____

_____

_____

Identify the accommodation(s) you are requesting:

_____

_____

_____

List all possible alternative accommodations:

_____

_____

_____

Requesting Individual's Signature: _____ **Date:** _____

ADA Coordinator Receipt of Request Date: _____

You may be asked to provide medical documentation substantiating your physical and/or mental impairment(s) and/or the need for the requested accommodation(s), including but not limited to when the limitation or impairment is not readily apparent and/or a requested accommodation does not clearly relate to your impairment(s). Any information you provide will be kept confidential and used solely to determine that the accomodation is needed.