1-866-68-FLAIR
beauty college

Physician Disability Verification Letter

Physician Name:

Patient named: _______________________ , on the attached **Flair Beauty College** has requested this disability verification Letter for above student name in order to verify her/his disability. This documentation is for the purpose of qualifying the student as eligible for disability-related services and is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). The eligible conditions and the authorized health physician who may verify them and sign this Disability Verification Letter, Disability Definitions and Documentation.

INSTRUCTIONS To Physician:

A. Physician Disability Verification Letter must be completed & sign.

B. At least one “major life activity” limitation must be checked in order for the student will be eligible.

C. The Disability Verification Letter must be completed and signed by the health physician qualified to diagnose and treat the specific condition.

D. Return the Disability Verification Letter by email or mail, unless requested otherwise by the student and attach any medical, psychological, and/or educational documentation.

Physician must indicate all restrictions or other recommendations, if appropriate. The completed Disability Verification letter must be returned to the school’s director before the student can receive disability-based accommodations. If you have any question please contact Owner/Director :

For More information please contact: Nick Niknejad; Administrator at 23754 Valencia Blvd, Valencia, CA 91355 @ 661-799-4995, or email available at flairbeautycollege@flairbeautycollege.com

Disability Verification Form

Licensed or Certified Physician Name: ____
Address: _____________________________________City: _____________________ Zip: __________________
Telephone Number: __________________ Cell Phone Number: _____________________ E-mail: __________________
Please provide the following complete information in order to qualify the student for eligibility and help determine the reasonable educational and physical accommodations:

1. Diagnosis: A: ____ B: ____________________________If applicable, DSM

IV Code: _____________ Sternness: Moderate____ Severe ____ Residual/ Reduction†

2. This condition substantially limits the following major life activities:

Standing___ Bending ____ Moving ____ Walking ___ Lifting ___ Breathing ___ Seeing ___ Reading ___ Hearing ___
Manual tasks____ Communicating ___ Sleeping ___ Eating ___ Carrying for one's Self ___ Crying ___ Slamming ___

3. Does it impact any of the following? (optional): Endurance ___ Forming/executing plan ___ Social Interaction

Overcoming Obstacles ___ Memory

4. List other limitations/information helpful in determining accommodations in an educational setting:
____
____
____

5. **The condition is: Stable ____ Prone to exacerbation** _____

6. **Duration of disability: Permanent/Chronic ____ Temporary** _____

7. **Under Medication ____ Not necessary ____**

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.

Physician Signature: __________________Title/License Number: _________________ Date: __________________

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INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at , a student must submit the student's Disability Form & Physician verification disability Letter, documenting a physical and/or Physician verification disability letter. The student's Disability Form & Physician verification disability Letter must be completed and signed by a licensed /certified Physician qualified to diagnose and treat the condition(s).

Step 1: Complete & sign the Student Information section of the Disability Form

Step 2: Notify School by receiving the form electronically (PandDoc . App) for completing the form.

Step 3: Provide this material to your treating professional.

Please return the Disability Verification Form by mail & Physician Disability letter, email or uploading electronically , unless requested otherwise by the student. (Attach any medical, psychological, and/or educational documentation.)

For More information please contact: Nick Niknejad; Administrator at 23754 Valencia Blvd, Valencia, CA 91355 @ 661-799-4995, **or email available at flairbeautycollege@flairbeautycollege.com**

Flair Beauty college

Accommodations and Disability Services Request Form

Please complete ALL SECTIONS of this form
You MUST include your signature before submitting this form.
Medical or other documentation of your disability must be on file to the Administrator. Please submit supporting documentation along with this form if you are requesting new or changed accommodations. This will assist the Administration Services in determining your eligibility for services and accommodations and in making the necessary arrangements. If your address(permanent) changes, please notify the Administrator immediately.

Student Information

Accommodation request from: _______________ Hour	**Today's Date**
Name:	**Address**
Home Phone:	**E-Mail:**
Cell Phone: Emergency Phone:	**Student ID:**
Program Schedule hours:	

Programs :	**Instructor**	**Theory**	**Lab**
1			
2			
3			
4			

Academic Accommodations Needed (check all that apply): Y/N

	Type of Accommodation	Comments:
	Sign Language Interpreter	
	FM System or other listening device	
	Visual Impairment	
	Hearing Impairment L	
	Speech and Language Impairment	
	Learning Disabilities	
	Acquired Brain Impairment	
	ADD/ADHD	
	Other Disabilities	
	Mobility, Orthopedic Impairment	
	Other communication	
	Assistance (please specify)	
	Van transportation on campus	
	Accessible classroom	
	Special furnishings in classrooms	
	Readers	

Academic Accommodations Needed (check all that apply): Y/N

	Books on tape	
	Online textbook	
	Everyone	
	Large Print	
	(please specify font size)	
	Note taker	
	Extended time for tests	
	Extended time on assignments	
	Distraction reduce space for tests.	

	(please specify)	
	Quiet room: 1-3 students	
	Private room	
	Other: (please specify)	

Accommodations Needed (check all that apply): Y/N

	Accommodation	Reason
	Wheelchair accessible room	
	Close proximity to classes	
	Single room	
	Quiet space	
	Non-smoking room	
	Communication accessible room	
	Special furniture at student cost	
	Other: (please specify)	

Disability	Disability Documentation
Please Explain:	**Documentation Provided to the Office of Disability Services:** **Yes _____ No _____** **Date Provided:**

Information Needed (check all that apply): Y/N

	Topic	What do you need to know?
	Help finding local physician	
	Wheelchair repair service	
	Hearing aid vendor	
	Counseling referral	
	Educational testing Advisor	
	Assistive technology for personal use	
	Finding help, personal care assistant, or house cleaning	
	Financial aid Assistant	
	Support group	
	Off campus transportation	
	Other: (please specify)	

PLEASE SIGN

I authorize the Administrator Services to provide verification of my disability to the Administrator at Flair Beauty College when necessary to clarify and substantiate my need for specific disability-related accommodations.
Flair Beauty College does not offer any kind of one-on-one tutoring, special training, special accommodationssign language or interpreter to any students although this services may be provided at student cost.

All heath issues requires a doctor note.

Signature: _____________________Refer/ __________ Date: _________

For determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services. Disability Community College Definition

Qualified Physician 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 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

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

Hard of Hearing: 1. Severe=avg. loss in better ear, 55 db. 2. MildModerate=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 more information on qualifying disabilities and/or signature and documentation requirements, contact the school's ADA coordinator at . Personal information recorded on the Disability Verification Form will be kept confidential in order to protect against unauthorized disclosure. Portions may be shared with Flair Beauty College 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).