LAKESHORE COLLEGE

Documentation of Deaf/Hard of Hearing

The Accommodation Services Office provides services to students who are deaf/hard of hearing. To determine eligibility for services, this office requires current comprehensive documentation of the hearing disability from an audiologist, speech and hearing specialist, or another medical professional.

If a comprehensive diagnostic report is available that provides the requested information, copies of that report can be submitted as documentation instead of this form.

Please Print Legibly

Student Name: _____

Date Completed: _____/_____/_____ Student's Date of Birth: _____/_____/_____

1. Diagnosis: _____

2. Date of diagnosis: _____/_____/_____

   Most recent contact with student/patient: _____/_____/_____

3. What is the severity of the hearing loss?
   Right ear:
   ☐ Mild ☐ Moderate ☐ Severe ☐ Profound
   Left ear:
   ☐ Mild ☐ Moderate ☐ Severe ☐ Profound

   Please include a copy of the most recent audiogram results

4. Is the hearing loss expected to remain stable or is it expected to decline? If it is expected to decline, describe the expected progression of the hearing loss.

   _____

   _____

   _____

   _____

5. Please list and describe the major life activities/functional limitations, both physical and academic, which are significantly impacted by the disability, and the degree of severity. ***Please note, if no major life activities are significantly impacted, no accommodations will be approved.***

_____

_____

_____

_____

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_____

6. Describe any situation or environmental conditions that might lead to an exacerbation of the condition.

_____

_____

7. What recommendations do you have regarding accommodations and/or auxiliary aids (e.g., Notetaker, FM system, captioning, sign language interpreting, etc.) in an academic setting? Please state your rationale for the accommodations and/or auxiliary aids you have recommended.

_____

_____

_____

_____

_____

_____

8. If any co-morbid conditions exist, please describe.

_____

_____

_____

_____

Provider Information

Name (Please Print):		
Medical Specialty:	**License #:**	
Address:		
Phone:	**Email:**	
Signature:		**Date:**

Please mail or fax this completed form and any additional information to:

Accommodation Services Office
Lakeshore College
1290 North Avenue
Cleveland, WI 53015

Fax: (920) 646.7262