Letter to the Prospective Student

Date: _____

Dear _____,

To initiate the request process, the Disability Verification Form is required to be completed by a Licensed or Certified Professional along with supportive documentation *(Refer to the attached Disability Definition and Documentation.)*. If there is more than one Health Care Professional responding on your behalf, each must complete a separate Disability Verification Form with supportive documentation.

Please be aware that your request cannot be considered until Coba Academy has received your completed form and the form from your Health Care Professional(s) with all the necessary information/documentation. You are urged to contact your Health Care Professional(s) office to confirm the Disability Verification forms have been mailed to the Disability Compliance Coordinator. Once the Disability Compliance Coordinator has received the documentation, the process can extend over a minimum of thirty days.

The following steps are required to determine if a student is eligible for disability-related services by Section 504 of the Rehabilitation Act and the Americans with Disability Act (ADA).

Instructions:

Step 1 Complete the following required documentation

- ✓ **Request for Reasonable Accommodations**
- ✓ **Student Information** on the form attached *(Disability Verification Form)*

Step 2 Provide the following Letter, Form and Attachments to a Licensed or Certified Professional :

- ✓ **Letter to The Health Care Qualified Professional**
- ✓ **Disability Verification Form**
- ✓ **The Disability Definition and Documentation**

Please be aware the Disability Compliance Coordinator reserves the right to request independent evaluation before granting or extending a request for a reasonable accommodation. In addition, the Disability Compliance Coordinator reserves the right to deny a request if the accommodation sought is not supported by the data in the assessment or documentation.

Sincerely,

Mr. Alan Gaxiola
Disability Compliance Coordinator

Coba ACADEMY
BARBERING • COSMETOLOGY • ESTHETICS

Request for Reasonable Accommodations

Student Name: _____
Home Address: _____
City/ State/ Zip Code: _____
Phone Number: _____
Email Address: _____

Program Interested in joining: Cosmetology Barber Esthetics

If there is more than one Health Care Professional responding on your behalf, each must complete a separate Disability Verification Form with supportive documentation.

Describe specifically the reasonable accommodation you are requesting and your reason for the request. Also, describe any alternative suitable accommodations. Attach additional sheets, if necessary.

_____

_____

_____

State the accommodation request. Attach additional sheets, if necessary.

_____

_____

_____

List all possible alternative accommodations. Attach additional sheets, if necessary.

_____

_____

_____

The Health Care Professional(s) who will be submitting information with respect to my condition(s) and accommodation(s) is (are):

_____

_____

_____

Applicant Signature:_____ **Date:** _____

Reviewed by The Disability Compliance Coordinator on: _____

Signature of The Disability Compliance Coordinator: _____

Coba ACADEMY
BARBERING • COSMETOLOGY • ESTHETICS

Disability Verification Form

Application Date: _____

STUDENT INFORMATION

Name: _____ Birthdate: _____
Address: _____
City: _____ Zip: _____
Telephone Number: (_____)_____-_____ Cell Phone Number: (_____)_____-_____
E-mail: _____

TO BE COMPLETED BY LICENSED OR CERTIFIED PROFESSIONAL

Licensed or Certified Professional Name: _____
Name of Health Care Office: _____
Address: _____
City: _____ Zip: _____
Telephone Number: (_____)_____-_____ Cell Phone Number: (_____)_____-_____
E-mail: _____

The first date you evaluated and/or treated this student for the condition: _____

Has the Health Care Professional reviewed our program curriculum and the catalog?
Yes **(Date: _____)** No
✓ https://coba.edu/

The most recent date you evaluated this student for the condition for which they accommodation is being required: _____

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

Item 1 - Diagnosis: A: _____ B: _____
If applicable, DSM IV Code: _____
Severity: Moderate Severe Residual/Remission

Item 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				

Item 3 - Does it impact any of the following? (Optional)

Stamina	Forming/executing plans	Social interaction
Overcoming obstacles	Memory	

Item 4 - List other limitations/information helpful in determining accommodations in an educational setting: _____

Item 5 - The condition is:

Stable Prone to exacerbation

Item 6 - Duration of disability:

Permanent/chronic Temporary, ***if temporary, select one:***

45 days or more

Less than 45 days - Expected duration: _____

Item 7 – A letter must cover the following information points:

- ✓ Why and how the proposed accommodation(s) will offset the effect of the disability; and,
- ✓ Whether any other accommodations would have a similar effect.

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.

Print Name: _____ 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:

Name: _____

Title: _____

Telephone: _____

TO BE COMPLETED BY THE DISABILITY COMPLIANCE COORDINATOR:

Disability Compliance Coordinator Name: _____

Application received by: _____

Application Status: Complete

In Complete - Missing Documents: _____

Optional:

Documentation review by outside agency/certified/licensed professionals

ABI:____	HEARING:____	MOBILITY:____	PSYCH:____
VISION:____	DDL:____	LD:____	OTHER:____
SPEECH:____	NONCLAIM:____		

Notes:

_____

_____

_____

Letter to The Health Care Qualified Professional

Date: _____

Dear Health Care Professional:

The prospective student by the name of _____ has requested that the disability be verified by a Qualified Professional. To initiate the request process, the attached document is required to be completed for the purpose of qualifying the prospective student is eligible for disability-related services and is required by Section 504 of the Rehabilitation Act and the Americans with Disability Act (ADA).

Locate the eligible conditions and provide supportive documentation from the qualified health professional who may verify. *(Refer to the attached Disability Definition and Documentation.)*

Instructions:

Step 1 Complete **Item 1 – 7** on the form attached *(Disability Verification Form)*

Step 2 Item 2 – At least one "major life activity" limitation must be checked in order for the student to be eligible.

Step 3 The Disability Verification Form must be completed and signed by The Health Qualified Professional to diagnose and treat the specific condition. *(Refer to the attached Disability Definition and Documentation.)*

Step 4 Please return the Disability Verification Form and attach any medical, psychological, and/or documentation to the Disability Compliance Coordinator to 663 North Euclid St., Anaheim, CA 92801.

Please include any restrictions or other recommendations, if appropriate.

We thank you for your prompt attention on behalf of your patient. If you have any question, please feel free to contact the Disability Compliance Coordinator to (714) 533 – 1400.

Sincerely,

Mr. Alan Gaxiola
Disability Compliance Coordinator

Coba ACADEMY
BARBERING • COSMETOLOGY • ESTHETICS

Disability Definitions and Documentation

Edibility for disability services is based on an individual's condition, which must:

1. Fall within diagnostics categories listed below; and
2. Impair a major life activity; and
3. Pose an educational limitation for which accommodation is required and appropriate.

Coba Academy uses the information requested on the Disability Verification Form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disable Students Programs and Services.

Disability	Community College 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	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. 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
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 Disability Compliance Coordinator. Personal information recorded on the Disability Verification Form will be kept confidential in order to protect against unauthorized disclosure. Portions may be shared with Coba Academy 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).