Disability Support Services
6200 Frank Ave. NW
North Canton, Ohio 44720-7299
(330) 494-6170 Ext. 4935
Fax (330) 305-6629
E-mail: disabilityservices@starkstate.edu

Mask Exception Verification Form

The information provided will not become part of the student's academic record, and confidentiality will be maintained.

Appropriate documentation should include, but is not limited to, the following:

1. **Completed by a licensed medical professional –**Disability Support Services (DSS) does not accept documentation completed by diagnosing/treating professionals related to the student requesting accommodations.

2. **The information provided on this verification form is maintained by DSS according to the guidelines of the Family Education Rights and Privacy Act (FERPA) of 1974**. This information may be released to the student upon their written request.

Please contact Disability Support Services at (330) 494-6170 ext. 4935 with questions.
Thank you for your assistance.

Disability Support Services
6200 Frank Ave NW, North Canton, OH 44720-7299
Phone: 330-494-6170 · ext. 4935
Fax: 330-305-6629
Email: disabilityservices@starkstate.edu

STUDENT INFORMATION
(to be completed by student)

First Name: _____ Last Name: _____

Phone: (_____) _____ - _____ DOB _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

I authorize the following individual or organization to release the information included in this document to Disability Support Services at Stark State College:

Student Signature: _____ Date: _____

DIAGNOSTIC INFORMATION
(to be completed by medical practitioner/specialist)

1. Please specify the specific diagnosis/disability: _____

_____

DSM-5 or ICD Diagnosis & Code: _____

Date of Diagnosis:_____ Date of last contact with student: _____

2. Please summarize why this individual's medical condition would preclude the use of a mask, based on your professional knowledge of the diagnosis, and your knowledge of how the individual would be adversely affected by the use of a mask. A face shield is the only permitted alternative to a mask.

_____

_____

_____

_____

_____

HEALTHCARE PROVIDER INFORMATION

I attest to the accuracy of the information contained in this document. Additionally, I understand that the information provided in this document will become a part of the student's record subject to the Family Educational Rights and Privacy Act (FERPA) of 1974, and may be released to the student upon written request.

Provider Name (PRINT): _____

Provider Signature:_____ Date:_____

Title:_____ License or Certification #_____

Address:_____

City:_____ State:_____ Zip: _____

Phone: (_____)_____-_____ Fax: (_____)_____- _____

Email address (if applicable): _____

Please have Doctor's office mail, e-mail or fax this completed form to:

Stark State College
Disability Support Services
6200 Frank Ave. NW
North Canton, Ohio 44720-7299
(330) 494-6170 Ext. 4935
Fax: (330) 305-6629 E-mail: disabilityservices@starkstate.edu