OFFICE OF DISABILITY SUPPORT SERVICES
DISABILITY VERIFICATION FORM

SECTION 1: TO BE COMPLETED BY THE STUDENT

NAME: _____ ID #: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ EMAIL: _____

NAME AND TITLE OF PHYSICIAN OR APPROPRIATE PROFESSIONAL: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ EMAIL: _____

DSS SERVICES THAT YOU ARE REQUESTING: _____

PERMISSION FOR RELEASE OF INFORMATION:

For purposes of determining reasonable accommodations, I authorize the release of the medical information and all other information requested on this form to California State University San Marcos and the CSU Chancellor's Office. This authorization will remain in effect for one year or until _____.

_____ _____

STUDENT'S SIGNATURE DATE

SECTION 2: TO BE COMPLETED BY CURRENT TREATMENT PROVIDER

DATE(S) OF EVALUATION OF YOUR CLIENT/PATIENT: _____

DATE OF MOST RECENT CONTACT WITH YOUR CLIENT/PATIENT: _____

WHAT IS THE NATURE OF YOUR CLIENT/PATIENT'S IMPAIRMENT?: _____

_____

HOW LONG IS THIS IMPAIRMENT EXPECTED TO LAST (i.e., number of days, weeks, months, years)? _____

_____

DOES THIS IMPAIRMENT SUBSTANTIALLY LIMIT (AS COMPARED TO THE AVERAGE PERSON) ONE OR MORE MAJOR LIFE ACTIVITIES (i.e., walking, breathing, sleeping, or learning) OF YOUR CLIENT/PATIENT? YES ☐ | NO ☐

IF YES, WHAT AREAS OF MAJOR LIFE ACTIVITY ARE IMPACTED?

WHAT FUNCTIONAL LIMITATOINS DOES YOUR CLIENT/PATIENT EXPERIENCE AS A RESULT OF HIS/HER IMPAIRMENT?

BASED ON HOW THIS IMPAIRMENT AFFECTS YOUR CLIENT/PATIENT'S ABILITY TO FUNCTION WITHIN AN ACADEMIC PROGRAM OR ENVIRONMENT, WHAT ADJUSTMENTS TO THE ACADEMIC ENVIRONMENT WOULD BE NEEDED IN ORDER FOR YOUR CLIENT/PATIENT TO HAVE EQUAL ACCESS TO ACADEMIC PROGRAMS? (PLEASE SPECIFY HOW EACH ADJUSTMENT SUGGESTED IS RELATED TO THE FUNCTIONAL IMPAIRMENT.)

PLEASE COMPLETE THE FOLLOWING SECTIONS THAT APPLY TO YOUR CLIENT/PATIENT'S IMPAIRMENT:

EFFECTS OF PRESCRIBED MEDICATIONS:

WHAT ARE THE EFFECTS OF ANY PRESCRIBED MEDICATIONS UPON YOUR CLIENT/PATIENT'S NORMAL COGNITIVE AND PHYSICAL CAPACITY?

HOW LONG DO YOU ANTICIPATE THAT YOUR CLIENT/PATIENT WILL EXPERIENCE THESE EFFECTS?

MOBILITY LIMITATIONS:

WHAT DISTANCE IS THIS INDIVIDUAL ABLE TO WALK WITHOUT SIGNIFICANT FATIGUE, INJURY, OR PAIN?

HOW MANY STEPS CAN THIS PERSON CLIMB? CAN HE/SHE WALK UP A SHARP INCLINE?

PERCEPTUAL LIMITATIONS:

VISUAL IMPAIRMENT:	VISUAL ACUITY	LEFT	_____	RIGHT	_____
	VISUAL FIELD	LEFT	_____	RIGHT	_____
HEARING IMPAIRMENT:	DB LOSS	LEFT	_____	RIGHT	_____

DOES YOUR CLIENT/PATIENT REQUIRE THE USE OF A SIGN LANGUAGE INTERPRETER?: ☐ YES | ☐ NO

NEUROLOGICAL IMPAIRMENTS:

PLEASE DESCRIBE THE NATURE OF YOUR CLIENT/PATIENT'S NEUROLOGICAL IMPAIRMENT AND ITS PROBABLE IMPACT ON THE EDUCATIONAL PROCESS (PLEASE ATTACH NEUROLOGICAL ASSESSMENT RESULTS):

PSYCHOLOGOCIAL OR LEARNING DISABILITIES (INCLUDING ADD/ADHD):

DSM-V DIAGNOSIS: _____

WHAT ARE YOUR CLIENT/PATIENT'S CURRENT SYMPTOMS (INCLUDE FREQUENCY, INTENSITY, AND DURATION)?

DESCRIBE THE DEFICITS IN COGNITIVE PROCESSING AND ACHIEVEMENT CAUSED BY THIS IMPAIRMENT:

DESCRIBE THE ASSESSMENT/EVALUATION PROCEDURES USED TO MAKE THE DIAGNOSIS (PLEASE ATTACH COPIES OF ASSESSMENT RESULTS):

DESCRIBE ANY CURRENT ACADEMIC DIFFICULTIES:

DESCRIBE HISTORICAL INFORMATION RELEVANT TO THE DIAGNOSIS (INCLUDING ANY EDUCATIONAL DIFFICULTIES PRIOR TO ENTRERING COLLEGE). FOR LD AND ADHD, INCLUDE SUPPORTING EVIDENCE OF CHILDHOOD ONSET OF SYMPTOMS (e.g., medical or academic records):

DESCRIBE ANY ENVIRONMENTAL, SOCIAL, EDUCATIONAL, OR LANGUAGE FACTORS THAT MAY CONTRIBUTE TO PSYCHOLOGICAL, LEARNING, OR ATTENTION PROBLEMS:

DESCRIBE ANY MEDICAL OR PSYCHOLOGICAL FACTORS NOT PREVIOUSLY MENTIONED THAT MIGHT CONTRIBUTE TO LEARNING OR ATTENTION PROBLEMS:

COMPLETE FOR ALL CLIENTS/PATIENTS:

CERTIFYING STATEMENT OF DISABILITY

I certify that the above referenced client/patient has a "physical or mental impairment that substantially limits one or more of the major life activities of such individual" as defined by the Americans with Disabilities Act.

In addition, I have the necessary professional qualifications to document my client/patient's disability, and the information provided on this form is accurate to the best of my knowledge.

SIGNATURE	LICENSE NUMBER	DATE

PLEASE RETURN TO:

DISABILITY SUPPORT SERVICES
CALIFORNIA STATE UNIVERSITY
SAN MARCOS, CA 92096-0001
PHONE: (760) 750 4905 | FAX: (760) 750 3445
TDD: (760) 750 4909