Cuyamaca College

Disabled Students Programs & Services (DSPS)
Disability Verification

The student named below may be eligible for services offered through this office. In order to provide these services, we must have verification of the student's disability.

To be completed by STUDENT (please print legibly in ink)

Student's Name: _____ ID #: _____ DOB _____

I authorize release of information requested below to **Disabled Students Programs & Services** at Cuyamaca College.

Student's Signature: _____ Date: _____

To be completed by LICENSED PROFESSIONAL (please print legibly in ink)

I certify that the above referenced client/patient has a **physical**, **mental**, or **learning impairment** that substantially limits one or more of the major life activities as defined by the Americans with Disabilities Act (ADA).

1. **Diagnosis (es)**:_____
   ☐ Permanent ☐ Temporary & expected to last through date _____
2. Medications/ treatments/ side effects: _____
3. Multi-axis DSM 5 classification(s): _____
4. Level of severity: ☐ Mild ☐ Moderate ☐ Severe
5. Date(s) of diagnosis (es):_____ Date of last office visit:_____
6. Provide medical records that directly support diagnosis (es) above (documentation/assessment/evaluation).
7. **Describe how the student's disability affects** his/her ability to function in **an academic/classroom environment**?

_____

_____

_____

_____

I have the necessary professional qualifications to diagnose my client/patient's disability. The information provided on this form is accurate.

Signature of Professional: _____ **Date:** _____

Name of Professional (please print): _____ **License #**: _____

Address: _____

Phone #: _____ Fax #:_____

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