



DISABILITY VERIFICATION FORM

Section I to be completed by student | Sections II & III to be completed by physician or other certified/licensed professional

SECTION I- To be completed by student

First Name: Last Name:

Date of Birth: Red ID Number:

I authorize the release of the information requested on this Disability Verification Form to the Student Ability Success Center at San Diego State University.

Student Signature: Date:

SECTION II- To be completed by physician or other certified/licensed professional

A. Diagnosis:

DSM or ICD Code(s):

This disability is: Permanent Temporary, expected to last through: (specify length of time)

B. Briefly describe the functional limitations of the disability, effect of medications, etc. on the ability to meet class requirements (attach additional pages if necessary).

C. Functional Impact Assessment

0= None 1= Mild/Moderate 2= Severe

Table with 4 columns: Major Life Activity, Degree of Impact, Major Life Activity, Degree of Impact. Rows include activities like Caring for Oneself, Talking, Hearing, Breathing, Seeing, Walking/Standing, Lifting/Carrying, Sitting, Performing Manual Tasks, Eating, Interacting w/Others, Sleeping, Thinking, Communicating, Learning, Working, and Other.

Please continue on to the next page for disability categories and your signature

SECTION III- To be completed by physician or other certified/licensed professional

Please complete all appropriate sub-sections that apply to your client/patient.

A. Perceptual Disability

Visual:

Visual Acuity Left: _____ Right: _____

Field Left: _____ Right: _____

Comments: _____

Hearing (Attach current audiogram if available):

dB Loss Left: _____ Right: _____

Comments: _____

B. Medical/Physical Disability

Briefly explain the nature of the medical/physical disability including diagnosis, medication effects, and their probable impact on the educational process.

C. Learning Disability

Briefly explain the nature of the learning disability and its functional limitations. Attach reports and/or test results, summary scores including computer scoring printouts, eligibility assessment and other comparable materials.

D. Neurological and/or Psychological Disability

Briefly explain the nature of the neurological and/or psychological disability and its probable impact on the educational process.

Name of Professional: _____ Title/Specialty: _____

(please print)

Certification or License #: _____ Email: _____

Address: _____ Phone: _____

I verify that the above information is complete and accurate to the best of my knowledge.

Signature of Professional: _____ Date: _____