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City College of San Francisco

Disabled Student Programs and Services

STUDENT DISABILITY VERIFICATION (SDV)

THIS SECTION MUST BE COMPLETED BY THE STUDENT.

In order to receive disability related services, a verification of disability must be provided.

Student Name: Last _______ First _______ Middle _______ CCSF ID# _______ Birthdate _______

Address ______________________ Phone ______________

City, State, Zip Code ______________________ Email ______________

I request that the professional designated, complete this form.

Name of Licensed or Certified Professional: ______________________

Address ______________________ Phone ______________

City, State, Zip Code ______________________ Fax ______________

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Please provide the following information in full in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis: ______________________

   If applicable , DSM V code and severity: ______________________

2. Functional limitations of disability and/or medication. Please check:

   - ☐ Speaking
   - ☐ Limited ambulation
   - ☐ Visual acuity
   - ☐ Poor concentration
   - ☐ Hearing loss
   - ☐ Taking class notes
   - ☐ Providing written assignments
   - ☐ Processing visual materials
   - ☐ Processing oral material
   - ☐ Slow processing of information
   - ☐ Easily distracted
   - ☐ Scheduling/registration
   - ☐ Disability management
   - ☐ Self-advocacy skills
   - ☐ Other: ______________

   ____

   ____

3. Duration of Disability:
   - ☐ Permanent/Chronic
   - ☐ If temporary, give estimated duration and/or date of re-evaluation ______________

4. Condition is: ☐ Stable ☐ Prone to exacerbations

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student upon written request.

Print Name: ______________________ Signature: ______________________

Verifying Professional

______________________ ______________________

Title Date

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis: ______________________

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Please attach educational, medical and/or psychological documentation requested on the other side of this form and return to:

☐ John Adams Center Ð DSPS

City College of SanSanSanSan

CONFIDENTIAL

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to City College of San Francisco, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies for use in educational planning . All information will be kept confidential and maintained as a part of my records with the Disabled Student Programs and Services Office. I authorize the release of information to include the following records: