DISABILITY VERIFICATION FORM

PLEASE RETURN OR FAX TO:
COLLEGE OF THE DESERT • Disabled Students Programs and Services
43-500 Monterey Avenue • Palm Desert, CA 92260
Phone (760) 773-2534 • Fax (760) 862-1329

The student named below may be eligible for special services at this college. In order to provide services we must have a verification of disability/diagnosis. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at College of the Desert.

____________________________________________________      __________________
Last Name             First Name         M.I.              Date of Birth
_________________________________________         ____________________________
Phone Number                                      Student ID#

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

1. Diagnosis: ___________________________________________________________________________
   If applicable, DSM V Code and Severity: _________________________________________________

2. Duration of Condition
   □ Permanent/Chronic
   □ If temporary, give estimated duration________________________________________________

3. Condition is:
   □ Stable                             □ Observable
   □ Prone to exacerbations           □ Non-observable

4. Prescribed Medication(s), Dosage and Side effects: ____________________________________________
   ____________________________________________________________________________________

5. Functional limitations of condition and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student.) Please check:
   □ Speaking                             □ Hearing loss
   □ Limited ambulation                    □ Taking class notes
   □ Visual acuity                         □ Providing written assignments
   □ Poor concentration                    □ Slow processing of information
   □ Other: _____________________________________________________________________________
   ____________________________________________________________________________________

6. Please list other special assistance needed: ________________________________________________
   ____________________________________________________________________________________

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 (FERPA) of 1974 and may be released to the student upon written request.

Signature ______________________________________    ______________________    _______________
Verifying Licensed Professional                                     Title/License #                                    Date

Name (printed) ___________________________________________________________________________
Address ________________________________________________________________________________
Phone ___________________________                                    FAX ___________________________

April 2015