



CONFIDENTIAL DISABILITY VERIFICATION

TO BE COMPLETED BY STUDENT

Last: _____ First: _____

SSN# (Last four digits): _____ SBVC SID# _____

Address: _____ City/State: _____ Zip: _____

Birth Date: _____ Telephone: _____

TO BE COMPLETED BY CERTIFIED/LICENSED PROFESSIONAL

Provider Name/Title (Print): _____

Address: _____ CITY: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

Please provide the following information to help determine reasonable educational accommodations:

1. **Diagnosis:** _____

Date of Diagnosis: _____

If Applicable:

Current Clinical DSM 5 and/or ICD 10 Diagnostic Code(s): _____

Indicate how side effects of medication affects student:

- Communicating/Speaking
- Limited Ambulation
- Processing Oral Material
- Easily Distracted
- Planning Classes
- Processing Visual Material
- Extremity Weakness
- Poor Concentration
- Taking Class Notes
- Hearing Loss
- Processing Information
- Vision
- Other _____

Level of hearing loss: (Attach Audiogram) Mild Moderate Severe Profound

- Uses aided hearing.
- Hearing loss interferes with client’s learning.
- Would benefit from amplification devices in an educational/vocational setting.

Visual impairment - I certify this client to be visually impaired according to the following criteria:

- A visual acuity of 6/21 (20/70) or less in the better eye after correction.
- A visual field of 20 degrees or less in the better eye after correction.
- Any progressive eye disease with a prognosis of becoming one of the above in the next two years.
- An uncorrectable vision problem or reduced visual stamina such that the applicants functions throughout the day as if his/her visual acuity is limited to 6/21 or less in the better eye after correction.

2. **Is the student/patient currently under your care?** Yes No

3. This condition substantially limits one or more of the following major life activities: (required)

- | | | | | |
|---------------------------------------|------------------------------------|--|--|--|
| <input type="checkbox"/> Bending | <input type="checkbox"/> Breathing | <input type="checkbox"/> Caring for self | <input type="checkbox"/> Communicating | <input type="checkbox"/> Concentrating/Learning |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Hearing | <input type="checkbox"/> Lifting | <input type="checkbox"/> Moving | <input type="checkbox"/> Performing manual tasks |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Seeing | <input type="checkbox"/> Speaking | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking |
| <input type="checkbox"/> Other: _____ | | | | |

4. **Condition is:** Prone to Exacerbation Stable

5. **Does it impact any of the following?** (Optional) Forming/Executing Plans Overcoming Obstacles
 Memory Social Interaction

6. **Duration of disability:**
 Permanent/Chronic Temporary Until Date: _____

7. **Describe the student's daily functional limitations in an educational setting and/or any recommended device(s):**

8. **Please provide any additional information/comments helpful in determining accommodations in an educational setting:**

Educational, medical, and/or psychological documentation should be attached and returned to:

College: San Bernardino Valley College
Student Accessibility Services (SAS)
701 South Mount Vernon Avenue
San Bernardino, CA 92410

Email: sbvcas@valleycollege.edu

Fax: (909) 889-7821

The information provided by you regarding the above-named student will be treated as confidential and will be disclosed by the College only as necessary for assessment and/or implementation of the requested services or accommodations.

Verifying Professional Name Printed

Verifying Professional Signature

License/Certification Number

Date