San Bernardino Valley College
Student Accessibility Services (SAS)
Phone: (909) 384 – 4443 ▪ Fax: (909) 889 – 7821

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
- ❒ Easily Distracted
- ❒ Extremity Weakness
- ❒ Hearing Loss
- ❒ Limited Ambulation
- ❒ Planning Classes
- ❒ Poor Concentration
- ❒ Processing Information
- ❒ Processing Oral Material
- ❒ Processing Visual Material
- ❒ Taking Class Notes
- ❒ 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)**

❑ Bending ❑ Breathing ❑ Caring for self ❑ Communicating ❑ Concentrating/Learning
❑ Eating ❑ Hearing ❑ Lifting ❑ Moving ❑ Performing manual tasks
❑ Reading ❑ Seeing ❑ Speaking ❑ Standing ❑ Walking
❑ 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: sbvcsas@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