CONFIDENTIAL

DISABILITY VERIFICATION (DV)

PLEASE RETURN OR FAX TO:
FULLERTON COLLEGE • DISABILITY SUPPORT SERVICES

321 E. Chapman Avenue • Fullerton, California 92832
Phone (714) 992-7099 • Fax (714) 992-9920

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 Fullerton College.

_____ _____
Last Name First Name M.I. Date of Birth

_____ _____
Phone Number Student ID#

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

1. Diagnosis: _____

   If applicable, DSM IV Code and Severity: _____

2. Duration of Condition
   - ☐ Permanent/Chronic
   - ☐ If temporary, give estimated duration_____

3. Condition is:
   - ☐ Stable
   - ☐ Prone to exacerbations
   - ☐ Observable
   - ☐ 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
   - ☐ Limited ambulation
   - ☐ Visual acuity
   - ☐ Poor concentration
   - ☐ Hearing loss
   - ☐ Taking class notes
   - ☐ Providing written assignments
   - ☐ Slow processing of information
   - ☐ Processing oral material
   - ☐ Processing visual materials
   - ☐ Easily distracted

   ☐ 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 _____