COLLEGE OF THE DESERT DISABILITY VERIFICATION FORM

PLEASE RETURN OR EMAIL/FAX TO:

College of the Desert
Disabled Students Programs and Services
43500 Monterey Avenue • Palm Desert, CA 92260
Phone: (760) 773-2534 • Fax: (760) 862-1329
Email: dsps@collegeofthedesert.edu

This form is to be completed by licensed professionals only.

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

<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 V Code and Severity:_____

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

3. Prescribed Medication(s), Dosage and Side Effects:_____

   _____

4. 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 select applicable item(s) below:**

☐ Speaking	☐ Hearing loss	☐ Processing oral material
☐ Ambulation/mobility	☐ Taking class notes	☐ Processing visual materials
☐ Visual acuity	☐ Manual manipulation of objects	☐ Easily distracted
☐ Poor concentration	☐ Slow processing of information	☐ Chronic pain
☐ Social communication/interaction	☐ Verbal communication	☐ Limited stamina

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 _____