

DISABILITY VERIFICATION (DV)

PLEASE RETURN, SCAN/EMAIL OR FAX TO:

SANTA ANA COLLEGE • DISABLED STUDENTS PROGRAM AND SERVICES

1530 W. 17th Street • Johnson Student Center, JSC-108 • Santa Ana, California 92706

Phone (714) 564-6295 • Fax (714) 285-9619 • Email DSPS@sac.edu

The student named below may be eligible for special services at this college. In order to provide services, we must have a verification that the student has a qualifying physical or mental condition.

_____	_____	_____	_____	_____
Last Name	First Name	M.I.	SAC ID#	Date of Birth
_____			_____	_____
Address			City	Zip Code

Please provide the following information, in full, in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis (DSM-V or ICD-10): _____

Diagnostic Code(s) (DSM-V or ICD-10) and Severity (if applicable): _____

2. Functional limitations of disability and/or medication. Please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Hearing | <input type="checkbox"/> Processing verbal material |
| <input type="checkbox"/> Limited mobility | <input type="checkbox"/> Taking class notes | <input type="checkbox"/> Processing visual materials |
| <input type="checkbox"/> Visual acuity | <input type="checkbox"/> Completion of written assignments | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Reduced course load | <input type="checkbox"/> Slow processing of information | <input type="checkbox"/> Poor attention/concentration |

Recommended units/term _____

Other: _____

3. Prescribed medication(s), dosage and side effects: _____

4. Duration of Disability

- Permanent/Chronic
- If temporary, give estimated duration and/or date of re-evaluation _____

5. Condition is:

- Stable
- Prone to exacerbations

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	License #	Title	Date
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Name (printed or stamped) _____

Address _____

Phone _____ Fax _____