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DISABILITY VERIFICATION FORM

PLEASE RETURN TO " 4 $
951-639-5305 (MVC) or 951-487-3305 (SJC)

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 Mt. San Jacinto Community College.

Name: _____ Date of Birth: _____

Phone Number: _____ Student ID#: _____

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

Diagnosis: _____

If applicable, DSM Code and severity: _____

Duration of condition

☐ Permanente/Chronic ☐ Temporary, End Date (Required) _____

Conditions

☐ Mild ☐ Moderate ☐ Severe

Prescribed medication(s) dosage and side effects: _____

_____

Functional limitations of conditions and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student). Please check

☐ Speaking ☐ Hearing Loss ☐ Processing Oral Material
☐ Limited Ambulation ☐ Taking Class Notes ☐ Processing Visual Material
☐ Visual Acuity ☐ Poor Concentration ☐ Slow Processing of Information
☐ Other: _____

" 4 $ professional staff, with consultation by the "S $ Director, may, through personal observation, verify the existence of an observable disability _____

" 4 $ Staff Signature: _____ Date: _____

I understand that the information

Revised