**CONFIDENTIAL**

# DISABILITY VERIFICATION (DV)

## PLEASE RETURN, SCAN/EMAIL OR FAX TO:
## SANTA ANA COLLEGE • DISABLED STUDENTS PROGRAM AND SERVICES

1530 W. 17th Street • The Village, VL-204 • 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:

   ☐ Speaking
   ☐ Limited mobility
   ☐ Visual acuity
   ☐ Reduced course load
   Recommended units/term _____
   ☐ Hearing
   ☐ Taking class notes
   ☐ Completion of written assignments
   ☐ Slow processing of information
   ☐ Processing verbal material
   ☐ Processing visual materials
   ☐ Easily distracted
   ☐ Poor attention/concentration

   ☐ 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 |

Name (printed or stamped) ______________________________________________

Address ______________________________________________

Phone ______________________ Fax ______________________