**CONFIDENTIAL**

# Disability Verification (DV)

**Please Return, Scan/Email, or Fax to:**
**Santa Ana College • Disabled Students Program and Services (DSPS)**
1530 W. 17th Street • Johnson Student Center, JSC-108 • Santa Ana, California 92706
Phone (714) 564-6295 • Email DSPS@sac.edu • Fax (714) 285-9619

**This section must be completed by the student.**

| Last Name | First Name | M.I. | SAC ID# | Date of Birth |
|---|---|---|---|---|
| | | | | |

| Address | City | Zip Code |
|---|---|---|
| | | |

In order to receive disability-related accommodations at Santa Ana College, a verification of disability from a qualified professional must be provided.

**The information below must be completed by a licensed professional.**

Please provide the following information to help the college determine reasonable educational accommodations for this student:

1. Diagnosis Name(s) (DSM or ICD): _____
2. Diagnosis Code(s) (DSM or ICD): _____ Severity: ◯ Mild ◯ Moderate ◯ Severe
3. How does this condition substantially limit the following major life activities? Please check all that apply:

Cognition
☐ Attention, Concentration, Distractibility
☐ Planning, Organization
☐ Memory
☐ Stamina

Physiological
☐ Mobility _____
☐ Bending/Lifting _____
☐ Sitting
☐ Standing

Sensory/Communication
☐ Hearing _____
☐ Vision _____
☐ Speaking

Academic
☐ Reading
☐ Writing

Other: _____

4. Duration of Disability: ◯ Permanent/Chronic ◯ Temporary (estimated duration/date of re-evaluation) _____
5. Prognosis: ◯ Stable ◯ Prone to exacerbations
6. Please list any recommended assistance: _____

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 _____

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the DSPS Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.