



Disabled Students Programs and Services (DSPS) Verification of Disability Form

If appropriate to your disability, please have your physician or appropriately licensed professional complete the bottom of this form and return to DSPS via email scdsps@saddleback.edu or fax (949) 347-1526.

To be completed by Student:

Student Name: _____ Date of Birth: _____

Student ID: _____ Phone Number: _____

I authorize the physician below to release information regarding my disability and functional limitations to Saddleback College DSPS by completing this form.

Physician Name: _____

Student Signature: _____ Date: _____

To be completed by Licensed Health-Care Professional:

To assist Saddleback College DSPS in determining reasonable educational accommodations to the student above, please complete the information below:

Diagnosis: _____ DSM5 or ICD-10 Code: _____

Permanent Temporary - Date of expected recovery: _____

Acquired Brain Injury

ADHD

Autism

Intellectual Disability

Learning Disability – Provide appropriate assessment scores

Mobility Impairment: _____

Deaf/Hard of Hearing – Corrected decibel levels: Left: _____ Right: _____

Visual Impairment – Corrected acuity: Left: _____ Right: _____

Mental Health: _____

Functional Limitations: The ways in which diagnosis affects the student in the education environment

Ability to maintain stamina

Focus and attention

Hearing

Memory

Mobility/ambulation

Oral communication/speaking

Physical regulation

Processing information

Sitting for extended periods of time

Social communication/interaction

Vision

Other: _____

Licensed Health-Care Professional:

Name: _____ Signature: _____

Title: _____ License Number: _____ Date: _____