



SADDLEBACK COLLEGE

28000 Marguerite Mission Viejo, CA 92692

949.582.4885 www.saddleback.edu

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

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

Student Name:	_____	_____	_____
	Last	First	Middle
Date of Birth:	_____	Student ID Number:	_____
	Phone Number:	_____	

Name of Physician/Specialist authorized to complete this form: _____

I authorize the above physician or specialist to release information regarding my medical or health condition and/or educational development to Saddleback College DSPS

Signature of Student

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:** _____

ADHD Permanent Temporary - Date expected recovery: _____

Autism

Intellectual Disability (ID)

Acquired Brain Injury (ABI)

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 the diagnosis affects the student in the educational environment

Ability to maintain stamina	Oral Communication/Speaking Physical	Vision
Behavior	Regulation	Other: _____
Focus and attention	Processing information	
Hearing	Sitting for extended periods of time	
Mobility/ ambulation	Social communication/social interaction	

Licensed Health-Care Professional:

Name: _____ Signature: _____

Title: _____ License Number: _____ Date: _____