Saddleback College

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 listed below to release information regarding my disability and functional limitations to Saddleback College DSPS through completion of this form.

Physician Name: _____

Student Signature: _____ Date: _____

To be completed by Licensed Health-Care Professional:

To support DSPS in determining educational accommodations, please complete the following:

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: _____

Please provide any additional relevant information to support accommodation determination:

_____

_____

_____

Physician Name: _____ **Signature:** _____

Title: _____ **License Number:** _____ **Date:** _____