Checked by_______________

Chaffey College Disability Programs & Services Medical Verification Release

Student's Name (Print): Last, ______ First ______ | Student Signature ______ Date ______

Date of Birth ______ | Social Security Number ______ | Hospital Record Number (if requesting information from a hospital) ______

In Case of Emergency: Name: ______ Relation: ______ Phone #: ( )

THIS PORTION IS TO BE FILLED OUT BY THE PHYSICIAN

The following is to be filled out by your physician. Please check appropriate disability; include specific diagnosis and limitations resulting form the disability.

DISABILITY	PRIMARY	SECONDARY	DIAGNOSIS	LIMITATIONS
Orthopedic	☐	☐		
Visual	☐	☐		
Hearing	☐	☐		
ADD/ADHD	☐	☐		
Psychological (Axis I or II, moderate or severe)	☐	☐		
Acquired or Traumatic Brain Injury or Stroke (CVA)	☐	☐		
Cardiac	☐	☐		
Hypertension	☐	☐		
Asthma	☐	☐		
Seizure Disorder	☐	☐		
Cancer	☐	☐		
Arthritis	☐	☐		
Chronic Fatigue Syndrome	☐	☐		
Back or Disc Injury	☐	☐		
Multiple Sclerosis	☐	☐		
Muscular Dystrophy	☐	☐		
Cerebral Palsy	☐	☐		
HIV Positive	☐	☐		
AIDS	☐	☐		
Other Respiratory Disorders	☐	☐		
Other:	☐	☐		

Chaffey College agrees to use the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disability Programs & Services. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure.

The above mentioned Primary disability is: ☐ Permanent OR ☐ Temporary & Ending Date: ______

Date of Onset: Primary Disability ______ Secondary Disability ______

Signature & Title of Certifying Professional ______

Name (Printed): ______

Address: ______

Phone #: ( ) ______

Fax #: ( ) ______

Please return this form to:

Chaffey College, Disability Programs & Services
5885 Haven Av
Rancho Cucamonga, CA 91737
Phone: (909) 652-6379
FAX: (909) 652-6386

Checked by_________________