

## Chaffey College DPS Disability 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 from the disability.*

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

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 mail this form to:

Chaffey College, Disability Programs & Services  
 5885 Haven Ave.  
 Rancho Cucamonga, CA 91737  
 Phone number : (909) 941 2379  
 Fax number: (909) 466-2834