Chaffey College Disability Programs & Services Disability Verification Form

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

XXX-XX-

Date of Birth | Social Security # | Student ID # | Phone # | E-mail

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. I hereby consent for Chaffey College DPS to contact certifying professional for additional information if needed.

THIS PORTION IS TO BE FILLED OUT BY THE PHYSICIAN (PLEASE PRINT)

Primary Diagnosis: ______ **AND ICD10/DSMV:** ______

☐ **Permanent /Chronic** ☐ **Temporary** **Date of Onset:** ______ **End Date or Re-Evaluation Date:** (only if temporary)

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Other: ______

Medications (Dosage / Frequency / Side Effects): ______

Secondary Diagnosis (If Applicable): ______ **AND ICD10/DSMV:** ______

☐ **Permanent /Chronic** ☐ **Temporary** **Date of Onset:** ______ **End Date or Re-Evaluation Date:** (only if temporary)

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Other: ______

Medications (Dosage / Frequency / Side Effects): ______

Functional Limitations (Certifying Professional must INITIAL next to each limitations resulting from the disabilities above):

initial	Gross motor skills	initial	Difficulty sitting for extended times
initial	Fine motor skills	initial	Difficulty standing for extended times
initial	Attention	initial	Difficulty using dominant hand
initial	Concentration	initial	Processing visual information
initial	Student may have to leave room intermittently	initial	Processing auditory information
initial	Requires highly structured learning environment	initial	Receptive language
initial	Long term memory	initial	Expressive language
initial	Short term memory	initial	Other: ______ Please Specify
initial	Walking	initial	Handicap Parking (Must Have DMV Placard)
initial	Hearing (Attach Verification)	initial	Learning Disability (Attach Verification)
initial	Vision (Attach Verification)		

Please submit form to:

Chaffey College Disability Programs & Services
5885 Haven Avenue
Rancho Cucamonga, CA 91737
Phone: (909) 652-6379
Fax: (909) 652-6385

Signature & Title of Certifying Professional: ______
Name of Treating Professional (Printed): ______
Agency Name: ______
Street Address: ______
City, State & Zip: ______
Phone # /Fax #: ______