City College of San Francisco **CONFIDENTIAL**

Disabled Student Programs and Services

STUDENT DISABILITY VERIFICATION (SDV)

THIS SECTION MUST BE COMPLETED BY THE STUDENT.

In order to receive disability related services, a verification of disability must be provided.

_____ _____ _____

Student Name: Last First Middle CCSF ID# Birthdate

Address _____ Phone _____

City, State, Zip Code _____ Email _____

I request that the professional designated, complete this form.

Name of Licensed or Certified Professional:_____

Address _____ Phone _____

City, State, Zip Code _____ Fax _____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL.

Please provide the following information in full in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis: _____

   If applicable, DSM V code and severity: _____

2. Functional limitations of disability and/or medication. Please check:

☐Speaking	☐Taking class notes	☐Easily distracted
☐Limited ambulation	☐Providing written assignments	☐Scheduling/registration
☐Visual acuity	☐Processing visual materials	☐Disability management
☐Poor concentration	☐Processing oral material	☐Self-advocacy skills
☐Hearing loss	☐Slow processing of information	☐Other: _____

   _____

   _____

3. Duration of Disability:
   - ☐Permanent/Chronic
   - ☐If temporary, give estimated duration and/or date of re-evaluation _____

4. Condition is: ☐Stable ☐Prone to exacerbations

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student upon written request.

Print Name: _____ Signature: _____

Verifying Professional

_____ _____

Title Date

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis: _____

_____

Please attach educational, medical and/or psychological documentation requested on the other side of this form and return to:

☐**John Adams Center – DSPS**
City College of San Francisco
1860 Hayes Street, Room 106
San Francisco, CA 94117
(415) 561-1001

Attn: _____

(Release of Information - Over)

☐**Ocean Campus – DSPS**
City College of San Francisco
50 Frida Kahlo Way, R323
San Francisco, CA 94112
Tel: (415) 452-5481
Fax: (415) 561-1040
dspsacom@ccsf.edu
Attn: _____

☐ **Mission Center – DSPS**
City College of San Francisco
1125 Valencia Street, Room 161
San Francisco, CA 94110
(415) 920-6038

Attn: _____

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RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to City College of San Francisco, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies **for use in educational planning**. All information will be kept confidential and maintained as a part of my records with the Disabled Student Programs and Services Office. I authorize the release of information to include the following records:

- ☐ Diagnosis of disability signed by an appropriate medical practitioner or psychologist
- ☐ Psychological testing and evaluation results
- ☐ Vocational rehabilitation plan
- ☐ Individual Education Plan (IEP)
- ☐ Learning Disabilities Assessment including raw scores for WAIS and W-J
- ☐ Other _____

This authorization shall remain in effect until revoked in writing by the undersigned.

Student _____ Date _____
Signature

Parent or Guardian _____ Date _____
Signature required for students under 18 years of age

A photocopy of this is as valid as the original.

☐ When my records are available at an outside agency, I hereby authorize the agency or professional named below to release to CCSF a verification of disability if needed for audit purposes. I understand this information will remain confidential.
Agency/Professional Name & Address:

_____
Student Signature Date

THIS SECTION MUST BE COMPLETED BY DSPS STAFF.

For DSPS Office Use Only

I hereby certify this student is eligible for DSPS services based on:
- ☐ Review of outside documentation by certificated DSPS staff
- ☐ Observation by certificated DSPS staff
- ☐ Assessment by certificated DSPS staff

P=PRIMARY
S=SECONDARY (more than one secondary is allowable)

_____	**H/HC/HL/HS DHH**	_____	**V/VB/VL BLIND & LOW VISION**	_____	**D ID**
_____	**B ABI**	_____	**M/MW PHYSICAL DISABILITY**	_____	**A ADHD**
_____	**L/LI LD**	_____	**O OTHER DISABILITY/SPEECH**	_____	**P MENTAL HEALTH**
_____		_____	**N NO DISABILITY**	_____	**U AUTISM**

CERTIFICATED SIGNATURE: _____

DATE: _____ INPUT DATE: _____

(Disability Verification - Over)