SAN DIEGO COMMUNITY COLLEGE DISTRICT (SDCCD)
DISABILITY SUPPORT PROGRAMS AND SERVICES (DSPS)
VERIFICATION OF DISABILITY

(A photo copy is valid as the original)

Student's Name: _____

Student ID#:_____ **Birth Date**:_____ **Last four SS#:**_____*

I hereby authorize the information requested below be released to DSPS at SDCCD.

_____ _____
Student's Signature Date

Physician or Verifying Professional: _____

Phone #: _____ **Fax #**: _____

Address: _____ **City:**_____ **State:**_____ **Zip:**_____

SDCCD uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by DSPS. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000

VERIFYING PROFESSIONAL: List all disabilities and include information describing the student's disabling condition.

DIAGNOSIS: _____

_____

Current DSM/ICD and Severity *(if applicable):* _____

Describe substantial limitations to learning and other major life activities: i.e., problem solving, mobility, distractibility, communication skills, medications or others that affect educational performance _____

_____

_____

DURATION:
___**Permanent/ Chronic** **Date of Diagnosis:** _____
___**Temporary (date of re-evaluation or estimated duration of disability)** _____

_____
Signature of Licensed/Certified Professional **Print Name**

_____
Professional Title (i.e., MD, Ph.D., etc,) **License/Certification #** **Date**

Please return by FAX or mail to the identified site below:

☐ **San Diego City College-DSPS**
1313 Park Blvd.
San Diego, CA 92101-4721
619-388-3513 Voice 619-388-3313 TDD
FAX 619-388-3801

☐ **San Diego Mesa College - DSPS**
7250 Mesa College Drive
San Diego, CA 92111-4998
619-388-2780 Voice 619-388-2974 TDD
FAX 619-388-2460

☐ **San Diego Miramar College - DSPS**
10440 Black Mountain Road
San Diego, California 92126-2910
619-388-7312 Voice 619-388-7301 TDD
FAX 619-388-7917

** Required for professional office*