



**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)** \_\_\_\_\_

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**Signature of Licensed/Certified Professional** \_\_\_\_\_ **Print Name** \_\_\_\_\_

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> <b>San Diego City College-DSPS</b><br>1313 Park Blvd.<br>San Diego, CA 92101-4721<br>619-388-3513 <u>Voice</u> 619-388-3313 <u>TDD</u><br><b>FAX 619-388-3801</b> | <input type="checkbox"/> <b>San Diego Mesa College - DSPS</b><br>7250 Mesa College Drive<br>San Diego, CA 92111-4998<br>619-388-2780 <u>Voice</u> 619-388-2974 <u>TDD</u><br><b>FAX 619-388-2460</b> | <input type="checkbox"/> <b>San Diego Miramar College - DSPS</b><br>10440 Black Mountain Road<br>San Diego, California 92126-2910<br>619-388-7312 <u>Voice</u> 619-388-7301 <u>TDD</u><br><b>FAX 619-388-7917</b> |
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\* Required for professional office