San Diego Community College District (SDCCD)
Disability Support Programs and Services (DSPS)

Verification of Disability

(A photo copy is valid as the original)

Student Name: _____

Student ID Number: _____ Birth Date: _____ Last four SSN*: _____

I hereby authorize the information requested below be released to DSPS at San Diego Community College District.

Student Signature: _____ Date: _____

*Required for professional office

Physician or Verifying Professional: _____

Telephone: _____ Fax: _____

Address: _____
Street City State Zip Code

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. § 1232g). 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 (MD, Ph.D., etc.) **License/Certification #** **Date**

Please return by email to the identified site below:

☐ **San Diego City College-DSPS**
citydsps@sdccd.edu

☐ **San Diego Mesa College - DSPS**
mesadsps@sdccd.edu

☐ **San Diego Miramar College - DSPS**
miradsps@sdccd.edu

Distribution: College DSPS Office