

DISABILITY VERIFICATION FORM

The student named below may be eligible for academic accommodations provided through the Services for Students with Disabilities (SSD) office. In order to authorize these services, we must have written verification of the student's disability from their practitioner. Please be assured that the information provided by you, will not appear in the student's academic record, and will remain confidential in SSD. This information will not be released to other persons unless instructed to do so by the student or as permitted by law.

Please note: student medical records supplied to this office constitute "educational records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

Student Information

Students Full Name: _____

Campus ID Number: _____ Birth Date: _____

Primary Phone Number: _____ E-mail: _____

Address (Local): _____

City: _____ State: _____ ZIP Code: _____

By signing you authorize the following individual or organization to release the following information to Services for Students with Disabilities at California State University, Fresno.

Student Signature: _____ Date: _____

Remainder of Document is to be Completed by Practitioner

Licensed Practitioner: _____

Type of License: _____ License No: _____

Phone: _____ Address: _____

City: _____ State: _____ ZIP Code: _____

How often do you see this student? _____ Date of Last Visit: _____

Length of time this student has been under your care: _____

DSM 5 Diagnosis(es)

Diagnosis: _____

Diagnosis: _____

Diagnosis: _____

This disability is considered: ☐ Permanent ☐ Temporary Until Date: _____

What is the prognosis for this student?

Which major life activity does this individual's disability substantially limit? (i.e. mobility, vision, memory, writing, etc.)

Recommended academic accommodations that this student may need to create an equitable learning experience:

Current medication(s):

Side effects that may impact physical, perceptual and/or cognitive performance in an academic setting:

I Certify this Individual Experiences a Disability as Defined by the Above:

Print Name: _____ Title: _____

Signature: _____ Date: _____

Please return this form to the address above. ALL INFORMATION IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY. Please be aware, however, that under FERPA the documents are subject to review as a part of the education records of the office of Services for Students with Disabilities.