CALIFORNIA STATE UNIVERSITY
FULLERTON
DISABILITY SUPPORT SERVICES

Office: University Hall, Room 101
Address: P.O. Box 6830 | Fullerton, CA 92834-6830
Telephone: (657) 278-3112 | Fax: (657) 278-2408
Email: dsservices@fullerton.edu
Web Address: http://www.fullerton.edu/dss

Print Form

DISABILITY VERIFICATION FORM

SECTION I - To be completed by applicant

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth (M/D/YYYY): _____ Campus-Wide ID#: | | | - | | - | | | |

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Physician or Educational Institution: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

Fax Number: _____

I authorize the release of the information requested on this Disability Verification Form to the Office of Disability Support Services at California State University, Fullerton.

Applicant Signature: _____ Date: _____

SECTION II - To be completed by physician or other certified/licensed professional

Please complete all appropriate sub-sections that apply to your client/patient

A. Complete for your client/patient with a *perceptual disability*

Visual:

Visual Acuity Left: _____ Right: _____

Field Left: _____ Right: _____

Comments: _____

Hearing:

dB Loss (please use current audiogram) Left: _____ Right: _____

Comments: _____

B. Complete for your client/patient with a *medical/physical disability*

Briefly describe the nature of the medical/physical disability including diagnosis, medication effects, and their probable impact on the educational process.

_____

_____

*** Please continue on to the next page for additional disability categories and your signature. ****

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C. Complete for your client/patient with a *learning disability*

Briefly describe the nature of the learning disability and its functional limitations. Attach reports and/or test results, including computer scoring printouts, eligibility assessment and other comparable materials.

_____

_____

D. Complete for your client/patient with a *neurological and/or psychological disability*

Briefly describe the nature of the neurological and/or psychological disability including diagnosis (DSM-IV as appropriate) and its probable impact on the educational process.

_____

_____

SECTION III - To be completed by physician or other certified/licensed professional for all clients/patients

A. Diagnosis: _____ **Prognosis:** _____

DSM or ICD Code: _____

This disability is:

- ○ Permanent
- ○ Temporary

If temporary, disabling condition is expected to last:

_____ (specify length of time)

- ○ Days
- ○ Weeks
- ○ Months

B. Briefly describe the functional limitations of the disability, effect of medications, etc. on the ability to meet class requirements.

_____

_____

Name of Physician or Certified/Licensed Professional* (please print): _____

Title/Specialty: _____ **Certification or License #:** _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

*If a trainee/intern provided the diagnosis, please provide his/her name and phone number:

Name: _____ Phone Number: _____

I verify that the above information is complete and accurate to the best of my knowledge.

Signature of Physician or Certified/Licensed Professional: _____

Date: _____