

CONFIDENTIAL
Barstow College
Disabled Student Programs & Services
Disability Verification

Date: _____

The student named below may be eligible for services at BARSTOW COLLEGE. In order to provide services we must have verification of disability as defined on the reverse side of this sheet.

Please send completed form to: DSP&S

Barstow College
2700 Barstow Rd.
Barstow, CA 92311

Name: _____
Last First M Social Security #

Address: _____
Street Address City Zip Date of Birth Phone Number

Please provide the following information in full in order to help determine reasonable educational accommodations to support this student.

1. Primary Diagnosis: _____

If applicable DSM IV Code and Severity: _____

2. Please describe how this condition substantially limits major life activities in the educational setting _____

Is there an impact on: Vision Hearing Mobility Concentration

3. Condition is Stable Prone to exacerbations

4. Duration of Disability: Permanent/Chronic Temporary—give estimated duration and/or date of evaluation: _____

1. Secondary Diagnosis: _____

If applicable DSM IV code and Severity: _____

2. Please describe how this condition substantially limits major life activities in the educational Setting: _____

Is there an impact on: Vision Hearing Mobility Concentration

If applicable, how do side affects of prescribed medications substantially limit major life activities in the educational Settings: _____

3. Condition is: Stable Prone to exacerbations

4. Duration of Disability: Permanent/Chronic Temporary – give estimated duration and/or date of Evaluation: _____

I understand that the information provided with this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student upon their written request.

Signature _____ Date: _____
(Certifying Professional) Title

Name (Please print) _____ Phone: _____ Ext: _____
Address: _____

Street City State Zip

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis:
