BARSTOW COMMUNITY COLLEGE DISTRICT
ACCESS DISABILITY VERIFICATION FORM

The student named below may be eligible for special services at this college. In order to provide services we must have a verification of disability/diagnosis. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Barstow Community College

Legal Name: ______________________ B Number: ______________________

Date of Birth: ______________________

Phone Number: ______________________

Please provide the following information IN FULL in order to help us determine reasonable educational accommodations to support this student:

Diagnosis: ______________________

If applicable, DSM code : ______________________

Duration of Condition:

☐ Permanent/Chronic ☐ Temporary/End Date (required): ______________________

☐ Mild ☐ Moderate ☐ Severe

Please attach prescribed medication(s) dosage and side effects:

Functional limitations of conditions and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student.) **Please check:**

☐ Speaking ☐ Hearing Loss ☐ Processing Oral Material

☐ Limited Ambulation ☐ Taking Class Notes ☐ Processing Visual Material

☐ Visual Acuity ☐ Poor Concentration ☐ Delayed Processing of Information

☐ Other: ______________________

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

Signature: ______________________ ______________________

Verifying Licensed Professional License Number

Name: ______________________ Phone: ______________________

Address: ______________________