

City College of San Francisco
Disabled Student Programs and Services
STUDENT DISABILITY VERIFICATION (SDV)

CONFIDENTIAL

THIS SECTION MUST BE COMPLETED BY THE STUDENT.

In order to receive disability related services, a verification of disability must be provided.

Student Name: Last _____ First _____ Middle _____ Medical Record# / CCSF ID# _____ Birthdate _____
Address _____ Phone _____
City, State, Zip Code _____ Email _____

I request that the professional designated, complete this form.

Name of Licensed or Certified Professional: _____
Address _____ Phone _____
City, State, Zip Code _____ Fax _____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL.

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

1. Diagnosis: _____

If applicable, DSM IV code and severity: _____

2. Functional limitations of disability and/or medication. Please check:

- | | | |
|---|---|--|
| <input type="checkbox"/> Speaking | <input type="checkbox"/> Taking class notes | <input type="checkbox"/> Easily distracted |
| <input type="checkbox"/> Limited ambulation | <input type="checkbox"/> Providing written assignments | <input type="checkbox"/> Scheduling/registration |
| <input type="checkbox"/> Visual acuity | <input type="checkbox"/> Processing visual materials | <input type="checkbox"/> Disability management |
| <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Processing oral material | <input type="checkbox"/> Self-advocacy skills |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Slow processing of information | <input type="checkbox"/> Other: _____ |

3. Duration of Disability:

- Permanent/Chronic
 If temporary, give estimated duration and/or date of re-evaluation _____

4. Condition is: Stable Prone to exacerbations

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 of 1974 and may be released to the student upon written request.

Print Name: _____ Signature: _____
Verifying Professional

_____ Title

_____ Date

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: _____

Please attach educational, medical and/or psychological documentation requested on the other side of this form and return to:

John Adams-De Avila – DSPS

City College of San Francisco
1860 Hayes Street
San Francisco, CA 94117
(415) 561-1000 Phone
(415) 561-1040 Fax
Attn: _____

Ocean Campus – DSPS

City College of San Francisco
50 Phelan Avenue, Box R323
San Francisco, CA 94112
(415) 452-5481 Phone
(415) 452-5565 Fax
Attn: _____
(Release of Information - Over)

Mission Campus – DSPS

City College of San Francisco
1125 Valencia Street Room 161
San Francisco, CA 94110
(415) 920-6038 Phone
(415) 920-6104 Fax
Attn: _____

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to City College of San Francisco, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies **for use in educational planning**. All information will be kept confidential and maintained as a part of my records with the Disabled Student Programs and Services Office. I authorize the release of information to include the following records:

- Diagnosis of disability signed by an appropriate medical practitioner or psychologist
- Psychological testing and evaluation results
- Vocational rehabilitation plan
- Individual Education Plan (IEP)
- Learning Disabilities Assessment including raw scores for WAIS and W-J
- Other _____

This authorization shall remain in effect until revoked in writing by the undersigned.

Student _____ Date _____
Signature

Parent or Guardian _____ Date _____
Signature required for students under 18 years of age

A photocopy of this is as valid as the original.

When my records are available at an outside agency, I hereby authorize the agency or professional named below to release to CCSF a verification of disability if needed for audit purposes. I understand this information will remain confidential.

Agency/Professional Name & Address:

Student Signature Date

THIS SECTION MUST BE COMPLETED BY DSPS STAFF.

For DSPS Office Use Only

I hereby certify this student is eligible for DSPS services based on:

- Observation by DSP&S professional staff with review by the DSP&S Coordinator
- Assessment by appropriate DSP&S professional staff
- Review of documentation provided by appropriate agencies or certified or licensed professionals outside of DSPS

P=PRIMARY
 S=SECONDARY FULL SERVICE (more than one secondary is allowable)

HEARING

VISUAL

D.D.L.

A.B.I.

MOBILITY

SPEECH

L.D.

OTHER

PSYCH

NON CLAIMABLE

CERTIFICATED SIGNATURE: _____

DATE: _____ INPUT DATE: _____

(Disability Verification - Over)