DISABILITY VERIFICATION

Yuba Community College District
Disabled Students Programs and Services
2088 N. Beale Rd. Building 1800
Marysville, CA 95901

Telephone: 530-741-6795
Fax: 530-741-6942
VP 866-274-7530

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Name_____SSN/ID#_____

Address_____

Birthdate_____Telephone#_____

In order to receive disability-related services at Yuba Community College a verification of disability must be provided. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional_____

Address_____

FAX_____Telephone#_____

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 his student.

1. Diagnosis_____Date of Onset_____
2. DSM IV Code and Severity (if applicable)_____
3. Please describe how this condition substantially limits major life activities_____
   _____
   _____
4. Condition is: ☐ Stable ☐ Prone to exacerbation
5. Duration of Disability: ☐ Permanent/Chronic
   ☐ Temporary (date of re-evaluation or estimated duration of disability)_____

Educational, medical, and/or psychological documentation and/or prior educational should be attached and returned to:

☐ College -- Address/Phone#/Attn._____

☐ Student -- See address above

I understand that the information provided by the verifying professional will become part of the student record, and may be released to the student upon their written request.

_____

Verifying Professional Signature Today's Date

If the above information is completed by someone other than the professional who made this diagnosis, please proved the name and address of the person who made the diagnosis in the space provided below.

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to Yuba Community College District, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulation, or policies for use in education planning. Al information will be kept confidential and maintained as part of my records with the Disabled Students Programs and Services. 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)
_____Detailed results of assessment, psychological or medical testing that led to diagnosis
_____Other

I further give permission for DSP&S specialists to discuss these records with other professionals at Yuba College who have a legitimate educational need to know, and give permission for DSP&S to forward these records to other educational institutions upon my written request.

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

Student Signature_____Date_____

Parent/Guardian_____Date_____
REQUIRED IF STUDENT IS UNDER 18

A PHOTOCOPY OF THIS IS AS VALID AS THE ORIGINAL

ADAPTED PHYSICAL EDUCATION VERIFICATION

☐ **(Complete Only If Box Is Checked)**

Our Adapted Physical Education Program is an individualized program of exercise for those unable to participate in regular physical education activity classes.

1. **Specific goals or emphasis desired**_____
   _____
   _____
   _____
2. **Recommended exercise program and activities**_____
   _____
   _____
   _____
3. **Activities to avoid**_____
   _____
   _____
   _____

Signature_____
Verifying Professional **Title** **Date**