DISABILITY VERIFICATION

Yuba College Disabled Students Programs and Services (DSPS)
2088 North Beale Rd., Building 1800
Marysville, CA 95901
Telephone: 530-741-6795 Fax: 530-741-6942 VP 866-274-7530 Email: dspsinfo@yccd.edu

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Name_____SSN/ID#_____

Address_____

Signature: X_____DOB_____ Phone_____

In order to receive disability-related services at Yuba 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 this 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:_____
6. ☐ Permanent/Chronic
   ☐ Temporary (date of re-evaluation or estimated duration of disability)_____

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**

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to the Yuba College District, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies for use in education planning. All 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 DSPS specialists to discuss these records with other professionals at Yuba College who have a legitimate educational need to know, and give permission for DSPS 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 (APE) VERIFICATION

(Complete only If APE is recommended)

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**