

COLLEGE OF THE SISKIYOU
DSP&S DISABILITY VERIFICATION
Disabled Student Programs and Services

STUDENT INFORMATION

Name: _____ *SSN/ID#: _____

Address: _____

Birth date: _____ Telephone # _____

In order to receive disability-related services at College of the Siskiyous, 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. DSM IV Diagnosis _____

2. Level of Severity: (Circle One)

Mild Moderate Severe Partial Remission Residual State

Date of Diagnosis: _____

3. Does this condition interfere with one or more of the following major life activities?

(Circle appropriate Residual State activities or circle **NONE**)

Caring Performing Walking Seeing Breathing Learning Working NONE
for self tasks

4. Describe the functional limitation: (e.g., easily distracted; poor concentration; difficulty focusing for extended periods of time; difficulty formulating and executing plan of action; difficulty overcoming unexpected obstacles; panics in unfamiliar surroundings and situations; etc.)

5. Condition is: stable prone to exacerbation

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

College of the Siskiyous, Learning Services, 800 College Ave., Weed, CA 96094

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: _____ **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 in the space provided below.

THIS SECTION MUST BE COMPLETED BY THE DSP&S STAFF
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I hereby certify this student is eligible for DSP&S 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 professional.

P=Primary

S=Secondary Full Service (more than 1 secondary is possible)

A.B.I	Hearing	Mobility
D.D.L.	L.D.	Other

Psych	Visual
Speech	Non Claimable

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services (DSP&S) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.