SAN JOAQUIN DELTA COLLEGE
DISABILITY SUPPORT PROGRAMS & SERVICES (DSPS)
DERICCO BUILDING, ROOM 234
5151 PACIFIC AVENUE, STOCKTON, CA 95207
PHONE: (209) 954-5151, EXT. 6272 ▪ FAX: (209) 954-3758

CONFIDENTIAL DISABILITY VERIFICATION

TO BE COMPLETED BY STUDENT ***Note: Documentation will be shred for students who do not complete the DSPS intake process within a calendar year. Should the student return, new disability verification must be submitted.***

LAST: _____ FIRST: _____

ADDRESS: _____ CITY: _____ ZIP: _____

BIRTH DATE: _____ SSN/ID#: _____ TELEPHONE: _____

TO BE COMPLETED BY CERTIFIED/LICENSED PROFESSIONAL

PROVIDER NAME (Print): _____ TITLE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

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

1. **Diagnosis:** _____ **Date of Diagnosis:** _____

If Applicable:

DSM-V-TR Code: _____ Severity: ☐ Moderate ☐ Severe ☐ Residual/Remission

In order to provide services, we must have:

- ❍ A verification of a psychological disability that is coded on Axis I or Axis II as moderate to severe and
- ❍ A Global Assessment of Functioning (GAF) score of 60 or below.

Axis I: _____ Axis II: _____ Axis III: _____
Axis IV: _____ Axis V: _____ GAF Score: _____

List current medication(s), impact, and adverse side effects:

Medication: _____ Impact: _____
Side effects experienced by patient: _____

Level of hearing loss: Indicate appropriate description(s). ◯ Mild ◯ Moderate ◯ Severe ◯ Profound

- ☐ Uses aided hearing.
- ☐ Hearing loss interferes with client's learning.
- ☐ Would benefit from amplification devices in an educational/vocational setting.

Visual impairment - I certify this client to be visually impaired according to the following criteria:

- ☐ A visual acuity of 6/21 (20/70) or less in the better eye after correction.
- ☐ A visual field of 20 degrees or less in the better eye after correction.
- ☐ Any progressive eye disease with a prognosis of becoming one of the above in the next two years.
- ☐ An uncorrectable vision problem or reduced visual stamina such that the applicants functions throughout the day as if his/her visual acuity is limited to 6/21 or less in the better eye after correction.

2. **Is the student/patient currently under your care?** ☐ Yes ☐ No

3. **This condition substantially limits one or more of the following major life activities: (required)**

☐ Bending	☐ Breathing	☐ Caring for self	☐ Communicating	☐ Concentrating/Learning
☐ Eating	☐ Hearing	☐ Lifting	☐ Moving	☐ Performing manual tasks
☐ Reading	☐ Seeing	☐ Speaking	☐ Standing	☐ Walking

☐ Other: _____

_____

4. **Condition is:** ☐ Prone to Exacerbation ☐ Stable

5. **Does it impact any of the following?** (Optional) ☐ Forming/Executing Plans ☐ Overcoming Obstacles ☐ Memory ☐ Social Interaction

6. **Duration of disability:** ☐ Permanent/Chronic ☐ Temporary until _____
If temporary (select one) ☐ Less than 45 days ☐ 45 days or greater

Expected duration: _____

7. **Describe the student's daily functional limitations in an educational setting and/or any recommended device(s):**

_____

_____

_____

8. **Please provide any additional information/comments helpful in determining accommodations in an educational setting:**

_____

_____

_____

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

☐ **College:** San Joaquin Delta College
Disabled Student Programs and Services
5151 Pacific Avenue
DeRicco Student Services Building, Room 234
Stockton, CA 95207

☐ **Email:** DSPS@deltacollege.edu

☐ **Fax:** (209) 954-3758

Place Medical Provider's Stamp Here:

The information provided by you regarding the above-named student will be treated as confidential and will be disclosed by the College only as necessary for assessment and/or implementation of the requested services or accommodations.

Verifying Professional Signature | License/Certification Number | Date