CONFIDENTIAL

SACRAMENTO CITY COLLEGE
DISABILITY RESOURCE CENTER
DISABILITY VERIFICATION

STUDENT SECTION

In order to receive disability-related services at Sacramento City College a verification of disability must be provided.

____
Student Name: Last First M. ID#/SS# Birthdate

Address____ Phone____________________

I request that the professional designated complete this form.

Name of Licensed or Certified Professional: ____

Address ______________________________City, State, Zip Code____________________

Phone (_______)_____________________________Fax (_______)_____________________________

PROFESSIONAL SECTION

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. Please describe how this condition substantially limits major life activities: _______________

____

____

If applicable, how do side effects of prescribed medications substantially limit major life activities in the educational setting: ____

____

3. Condition is: [ ] Stable [ ] Prone to exacerbations
4. Duration of Disability
   [ ] Permanent/Chronic
   [ ] If temporary, give estimated duration and/or date of re-evaluation____________________

I understand that the information provided with 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 their written request.

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 return to:

[ ] Sacramento City College
3835 Freeport Blvd.
Sacramento, CA 95822-1386
Attn: Disability Resource Center
Voice: (916) 558-2087 / Fax: (916) 650-2781

[ ] Student (see above for address)

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to Sacramento City College, 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 part of my records with the Disability Resource Center. 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 the diagnosis
[ ] Other____

I further give permission for DRC specialists to discuss these records with other professionals at Sacramento City College who have a legitimate educational need to know, and I give permission for the DRC 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____ Date__________

Parent or guardian______________________________Date__________
Signature required for students under 18 years of age

A photocopy of this is as valid as the original.

(Release of Information - Over)

DSPS Office Use Only

I hereby certify this student is eligible for DRC services based on:
[ ] Observation by DRC professional staff with review by the DRC Coordinator
[ ] Assessment by appropriate DSP&S professional staff
[ ] Review of documentation provided by appropriate agencies or certified or licensed professionals outside of DRC

P=PRIMARY S=SECONDARY FULL SERVICE

☐ A.B.I. ☐ HEARING ☐ MOBILITY ☐ OTHER

☐ D.D.L. ☐ VISUAL ☐ PSYCH ☐ SPEECH

☐ DR CLIENT (0 OR 1)

CERTIFICATED SIGNATURE______________________________ DATE__________

[ ] FALL [ ] SPRING [ ] SUMMER ________ INPUT DATE/INITIALS__________

Rev January 2004