Student Accessibility Services
2100 Moorpark Avenue, San Jose, CA 95128-2799
Phone: 408-288-3746
Fax: 408-971-8201
Email: sjcc.sas@sjcc.edu

VERIFICATION OF DISABILITY

THIS SECTION BELOW MUST BE COMPLETED BY THE STUDENT

Date: _____ Student ID#: _____

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Phone number: _____ Secondary Phone number: _____

THIS SECTION BELOW MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

The student named above is requesting services at San Jose City College. In order to provide appropriate services to this student, we are required to obtain the following verification of disability/diagnosis

Name of Licensed/Certified Professional: _____

Title/License #: _____

Address: _____ City: _____ State: _____

Telephone Number: _____ Fax Number: _____

To assist us in determining reasonable educational accommodations, please provide the following information IN FULL.

Diagnosis: _____

DSM IV Code and Severity (if applicable): _____

Condition is:

☐ Stable ☐ Prone to exacerbation

Duration of Condition:

☐ Permanent/Chronic ☐ Temporary until date: _____/_____/_____

Prescribed Medications and Dosage: _____

Functional limitations: Indicate how the disability, condition and/or side effects of the medication affect the student.

_____

_____

_____

Please list other limitations/information helpful in determining accommodations in an educational setting:

_____

_____

_____

I understand that the information provided On this form will become part of the student record, and may be released to the student upon their written request.

Signature: _____ _____

Verifying Licensed/Certified Professional Date

Please return this form to the SAS office as soon as possible.
A PHOTO COPY IS AS VALID AS THE ORIGINAL