College of the Sequoias
DISABILITY VERIFICATION

Please return this form and documentation to:
Mail: College of the Sequoias, Access & Ability Center, 915 S. Mooney Blvd., Visalia, CA 93277
Fax: (559) 730-3803

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Name: _____ Student ID #: _____

Address: _____ Telephone #: _____

Birth Date: _____ Cell #: _____

In order to receive disability-related services at College of the Sequoias a verification of disability must be provided. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional: _____

Address: _____

Telephone #: _____ FAX #: _____

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:

Diagnosis: _____

DSM V Code and Severity (if applicable): _____

Condition is: ☐ Stable
☐ Prone to exacerbation

Duration: ☐ Permanent/Chronic
☐ Temporary (Re-evaluation date 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 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.

_____

Additional Notes:

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