PSYCHOLOGICAL DISABILITY VERIFICATION

Disability Resource Center
Laney College
900 Fallon St.
Oakland, CA 94607
(510) 464-3428 Fax: (510) 986-6913

Student Name:

_____
Last First M.I.

Address:

_____
Street Apt. No. City State Zip Code

SSN/Student ID No: _____ Birth Date:

_____/_____/_____
Month Day Year

Telephone No.: (_____)_____-_____ Medical Record No.:

_____

Maiden Name or Other Name Used:

_____

In order to receive disability-related services at Laney College, a verification of disability must be provided. The student requests that the professional designated below complete this form.

Name of Licensed or Certified Professional: _____

Address: _____

Telephone No.: (_____)_____ Fax No.: (_____)_____

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

In order to help determine reasonable educational accommodations to support this student, please provide the following information in full:

1. DSM V TR
   Axis I Code(s): _____ Diagnosis(es): _____
   _____ _____
   Axis II Code(s): _____ Diagnosis(es): _____
   _____ _____
   Axis III: _____
   Axis IV: _____
   Axis V: (Current GAF) _____ (Highest GAF) _____
   Date of DSM Diagnosis: _____
2. Please list the functional limitations of this condition: ☐ Caring for self ☐ Course/vocational planning ☐ Interacting with others ☐ Communication ☐ Handling unfamiliar surroundings/situations ☐ Memory ☐ Easily distracted ☐ Poor concentration ☐ Difficulty organizing thoughts ☐ Other: _____
3. Please describe how this condition substantially limits major life activities:
   _____
   _____
4. Condition is: ☐ Stable ☐ Prone to exacerbation
5. Durability of Disability: ☐ Permanent/Chronic ☐ Temporary (estimated duration of disability): _____

Please attach and return any additional supporting educational, medical, and/or psychological documentation to the college unless otherwise specified by the student.

I understand that the information provided will become part of the student's educational record, and may be released to the student upon written request.

X_____

_____

Verifying Professional Signature and Credentials **Date**

_____

_____

Print Name **Clinical License Number**

Additional Comments:

_____

_____

_____

_____

_____

_____

_____

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). Personal Information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be share 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. 123(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing a 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.