MERRITT COLLEGE DISABILITY VERIFICATION FORM

Counselor:_____ **Please return to DSP via FAX 510-434-3888**

Student Accessibility Services

12500 Campus Drive, Oakland, CA 94619 Phone: (510) 436-2429

THIS SECTION MUST BE COMPLETED BY THE STUDENT:

Name:_____ ***SSN/ID#**:_____

Address:_____

Birth Date:___/___/___ **TELEPHONE**:(_____)_____ **email:** _____

Mo/day/year (area code)

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

Student Signature:_____ **Date:** _____

Name of Licensed or Certified Professional:_____

Address:_____

FAX #:_____ **TELEPHONE #**:_____

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:

1. Diagnosis:_____
2. DSM IV Code and Severity (if applicable)_____
3. Please describe how this condition substantially limits major life activities:_____

_____

_____

4. Condition is: ☐ stable ☐ prone to exacerbation
5. Duration of Disability: ☐ Permanent/Chronic ☐ Temporary (date of re-evaluation or estimated duration of disability)_____

Educational, medical, and/or psychological documentation should be attached and returned to the address above.

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 written request.

Verifying Professional Signature: **License #:** **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.