



San Diego Community College District (SDCCD)
 Disability Support Programs and Services (DSPS)

Verification of Disability
 (A photo copy is valid as the original)

Student's Name: _____

Student ID Number: _____ Birth Date: _____ Last four SSN*: _____

I hereby authorize the information requested below be released to DSPS at San Diego Community College District.

Student Signature: _____ Date: _____

*Required for professional office

Physician or Verifying Professional: _____

Telephone: _____ Fax: _____

Address: _____
 Street City State Zip Code

SDCCD uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by DSPS. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with 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. § 1232g). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your 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.

VERIFYING PROFESSIONAL

(List all disabilities and include information describing the student's disabling condition)

DIAGNOSIS: _____

Current DSM/ICD and severity (if applicable): _____

Describe substantial limitations to learning and other major life activities: (i.e., problem solving, mobility, distractibility, communication skills, medications or others that affect educational performance) _____

DURATION:

Permanent/ Chronic Date of Diagnosis: _____

Temporary (date of re-evaluation or estimated duration of disability): _____

Signature of Licensed/Certified Professional _____

Print Name _____

Professional Title (MD, Ph.D., etc.) _____

License/Certification # _____

Date _____

Please return by FAX or mail to the identified site below:

San Diego City College-DSPS
 1313 Park Blvd.
 San Diego, CA 92101-4721
 619-388-3513 Voice 619-388-3313 TDD
 FAX 619-388-3801

San Diego Mesa College - DSPS
 7250 Mesa College Drive
 San Diego, CA 92111-4998
 619-388-2780 Voice 619-388-2974 TDD
 FAX 619-388-2460

San Diego Miramar College - DSPS
 10440 Black Mountain Road
 San Diego, California 92126-2910
 619-388-7312 Voice 619-388-7301 TDD
 FAX 619-388-7917