**DISABILITY VERIFICATION FORM**

PROGRAMS & SERVICES FOR STUDENTS WITH DISABILITIES (PSSD)

BERKELEY CITY COLLEGE

***STUDENT SECTION***

In order to receive support services from PSSD, a disability verification form must be completed and by agency or licensed verifying professional.

|  |  |  |
| --- | --- | --- |
| **Student Information** | | |
| Last Name | First Name | Middle Initial |
|  |  |  |
| Street Address | City, State, Zip | Student ID |
|  |  |  |
| MRN or last four digits of SSN | Phone Number | Date of Birth |
|  |  |  |

***PROFESSIONAL SECTION***

Please provide the following information in full to help determine reasonable educational accommodations to support this student.

|  |  |
| --- | --- |
| Name of Licensed or Certified Professional | Professional License No. |
|  |  |
| Address | Email Address |
|  |  |
| Fax Number | Phone Number |
|  |  |

|  |  |  |
| --- | --- | --- |
| Diagnosis(es): | | |
|  | | |
| DSM 5 Code and Severity (if applicable): | | |
|  | | |
| Please describe how condition(s) substantially limits major life activities: | | |
|  | | |
| Recommended academic accommodations: | | |
|  | | |
| Prescribed medications: | | |
|  | | |
| Condition is: | Stable | Prone to exacerbation/Chronic |
| Duration of disability: | Permanent | Temporary  Estimated duration: \_     \_\_ |

I understand that the information provided with this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student upon their written request.

|  |  |  |
| --- | --- | --- |
| Signature of Verifying Professional | Title | Date |
|  |  |  |