CONFIDENTIAL

SACRAMENTO CITY COLLEGE
DISABILITY SERVICES & PROGRAMS for STUDENTS (DSPS)
DISABILITY VERIFICATION

STUDENT SECTION

In order to receive disability-related services at Sacramento City College a verification of disability must be provided.

Student Name: Last First M. ID# Birth date

Address Phone

I request that the professional designated complete this form.

Name of Licensed or Certified Professional:

Address City, State, Zip Code

Phone ( ) Fax ( )

PROFESSIONAL SECTION

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

1. Diagnosis:

   If applicable, DSM V Code and Severity:

2. Please describe how this condition substantially limits major life activities:

If applicable, how do side effects of prescribed medications substantially limit major life activities in the educational setting:

3. Condition is: ☐ Stable ☐ Prone to exacerbations
4. Duration of Disability
   - ☐ Permanent/Chronic
   - ☐ If temporary, give estimated duration and/or date of re-evaluation

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
Verifying Professional Title 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:

Please return to:

☐ Sacramento City College
3835 Freeport Blvd.
Sacramento, CA 95822-1386
Attn: Disability Services & Programs for Students (DSPS)
Voice: (916) 558-2087 / Fax: (916) 650-2781

☐ Student (see above for address)

SCC/Disability Services & Programs for Students (DSPS)
(916) 558-2087 ● Fax: (916) 650-2781

RELEASE OF INFORMATION

I, the undersigned, consent to the release of specific written and verbal information regarding my disability to Sacramento City College, consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies for use in educational planning. All information will be kept confidential and maintained as a part of my records with the California Community College Disabled Student Programs & Services (DSP&S) Office. No medical condition or diagnosis information will be shared outside of the DSPS office except as provided below.

The Los Rios 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) Offices. 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 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. 1232(g)). 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 et seq. *(Form Updated 9/21/2012)*

This authorization shall remain in effect until revoked in writing by the undersigned, but in no event more than one year from the date it is signed.

Please initial:

____ Diagnosis of disability signed by medical practitioner or psychologist
____ Psychological testing and evaluation results
____ Post-Secondary Institution School: _____
____ Department of Rehabilitation Branch: _____
____ Vocational rehabilitation plan Agency: _____
____ Veteran's Administration
____ Alta Regional Center
____ Individual Education Plan (IEP) School: _____
____ Detailed results of assessment, psychological or medical testing for diagnosis
____ Learning Disabilities testing and raw scores From: _____
____ Other: _____

Print Name: _____ Student ID#: _____

Student Signature: _____ Date_____

****

I give permission to the DRC to communicate directly with:

Name _____ Relationship_____

Student Signature: _____ Date_____

I revoke this communication permission effective on the date signed below:

Student Signature: _____ Date_____

A photocopy of this is as valid as the original.

Rev. 11/18/19 FM