DISABILITY VERIFICATION

PLEASE RETURN OR EMAIL TO:

COMPTON COLLEGE ◆SPECIAL RESOURCE CENTER

1111 E. Artesia Blvd. ◆Compton, California 90221
Phone: (310) 900-1600 x 2402 ◆Email: SpecialResourceCenter.edu

STUDENT INFORMATION - TO BE COMPLETED BY STUDENT

NAME: ID #: BIRTHDATE:

ADDRESS: CITY: ZIP:

PHONE: CELL PHONE: EMAIL: @COMPTON.EDU

I HEREBY AUTHORIZE MY HEALTH PROVIDER TO RELEASE THE INFORMATION REQUESTED BELOW STUDENT

SIGNATURE (Click to sign)

TO BE COMPLETED BY PROFESSIONAL

NAME OF LICENSED/CERTIFIED PROFESSIONAL (Please print)

ADDRESS: CITY: ZIP:

PHONE: EMAIL:

PLEASE PROVIDE THE FOLLOWING INFORMATION IN FULL IN ORDER TO QUALIFY THE STUDENT FOR ELIGIBILITY AND HELP US DETERMINE REASONABLE EDUCATIONAL AND PHYSICAL ACCOMMODATIONS :

1. DIAGNOSIS: (REQUIRED, PLEASE PRINT)

IF APPLICABLE, DSM CODE (S):

A.

B.

SEVERITY:

MODERATE ☐ **SEVERE** ☐ **RESIDUAL/ REMISSION** ☐

2. HOW DOES THIS CONDITION LIMIT THIS STUDENT'S ABILITY TO LEARN OR HOW DOES THIS CONDITION SUBSTANTIALLY LIMIT MAJOR LIFE ACTIVITIES?

3. (OPTIONAL) CONDITION IS: STABLE ☐ **PRONE TO EXACERBATION** ☐

4. (REQUIRED) DURATION OF DISABILITY: TEMPORARY ☐ **PERMANENT/CHRONIC** ☐

5. (OPTIONAL) PRESCRIBED MEDICATIONS:

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 (FERPA) and may be released to the student on their written request

SIGNATURE: **LICENSE #:** **DATE:**