CALIFORNIA STATE UNIVERSITY
FULLERTON
DISABILITY SUPPORT SERVICES

800 N. State College Blvd. Fullerton, CA 92832
P: 657-278-3112 or F: 657-278-2408

Student Name: (Please TYPE or PRINT clearly) _____ Birthdate: _____

I am requesting academic support services through Disability Support Services at CSUF which requires current and comprehensive documentation of my disability and functional limitations. Please respond to the following questions as soon as possible and return to DSS by mail or fax. I authorize Disability Support Services at CSUF to contact you if clarification is needed.

Student Signature: _____ Date: _____ CWID #: _____

SECTION II: To be completed by professional only

DISABILITY VERIFICATION FORM

Please provide the following information regarding the student above to help us determine reasonable educational and physical accommodations:

1. Diagnosis: _____

If applicable: DSM V Code: _____ Severity: ❒ Moderate ❒ Severe ❒ Remission

❒ Visual Impairment (attach prescription) ❒ Hearing (attach audiogram)

2. This condition substantially limits the following major life activities: (examples include sleeping, eating, writing, etc.)

3. List other functional limitations/information helpful in determining accommodations in an educational setting:

4. Medication Side Effects:_____

5. Duration: ❑Permanent (lasting longer than 6 months) ❑Temporary – End Date: _____

6. Date of Diagnosis:_____ Date of last contact:_____

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

Name of Physician or Certified/Licensed Professional: _____

Title/Specialty: _____ License or Certification #:_____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: _____

I verify that the above information is complete and accurate to the best of my knowledge and certify that I am not related to this student.

Signature of Physician or Certified/Licensed Professional: _____ Date: _____