Disability Support Services
900 Otay Lakes Road
Chula Vista, CA 91910
Phone (619) 482-6512
Fax (619) 482-6511
VP (619) 207-4480

Date:

Physician and/or Agency

Street Address

City **State** **Zip**

Phone **Fax**

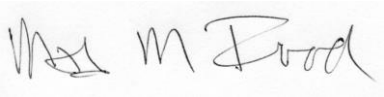
Dear _____ ,

_____ is a student who is attending or planning to attend Southwestern College. He/She has applied for one or more special services as a direct result of his/her disability. We are required to obtain written verification from an appropriate agency and/or physician regarding the nature of the student's disability, resultant educational limitations, and accommodation needs.

You have been identified by this student as someone who can verify his/her disability. Attached you will find the signed release for disability verification for you to complete, and return to us. If your verification is based on a report from a physician, psychologist, or other specialist, a copy of the report must be attached.

Should you require further information regarding this request, please feel free to call us at (619) 482-6512. Thank you for your assistance and for taking the time from your schedule to provide us with this information.

Sincerely,



Malia M. Flood, Ph.D,
Director, Southwestern College Disability Support Services

To request this material in alternate format, please call:
voice (619) 482-6512 or VP (619) 207-4480

SOUTHWESTERN COLLEGE

Disability Support Services
Disability Verification

This section to be completed by the student

Name: _____ _____ _____
Last *First* *M*

Address: _____
Street *City* *State* *Zip Code*

Phone: _____ Birthdate: _____ Kaiser Medical # _____

I hereby authorize the release of any confidential information to verify my disability in accordance with Section 504 of the Federal Rehabilitation Act and the Americans with Disabilities Act to Disability Support Services at Southwestern College. A copy of this document is as valid as the original. This authorization shall remain in effect until revoked in writing by the undersigned.

Student's self-identified disability: _____

_____ _____
Student's Signature Date

Southwestern College uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by DSS. 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. 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 the California Education Code Sections 67310-67312, and 84850, and California Code of Regulations, Title 5, Section 56000.

This section to be completed by the licensed or certified professional

1. Description of disability(ies): _____
2. DSM/ICD and severity (if applicable): _____
3. Date of diagnosis: _____
4. Please check any applicable functional/educational limitations:
   - ❑ test taking ❑ notetaking ❑ memory ❑ cognitive processing ❑ problem solving
   - ❑ easily distracted ❑ poor concentration ❑ difficulty focusing for extended periods of time
   - ❑ difficulty formulating and executing plan of action ❑ difficulty overcoming unexpected obstacles
   - ❑ panics in unfamiliar situations ❑ loss of visual acuity ❑ degree of hearing loss
   - ❑ Other limitations: _____
5. Prescribed medications and dosage: _____
6. The above mentioned disability(ies) is/are:
   - ❑ Permanent/Chronic ❑ Temporary: Days _____ Weeks _____ Months _____
7. Accommodations recommended: _____
8. This disability is: ❑ Observable ❑ Not observable

If this form is completed by someone other than the professional who made the diagnosis, the name and address of the person who made the diagnosis should also be listed below.

_____
Signature of Licensed/Certified Professional *PRINT NAME*

_____
Professional Title (ie:, MD, Ph.D., etc,) *License/Certification #* *Phone* *Date*

Please fax to: (619) 482-6511 OR mail to: Disability Support Services, Room S108, Southwestern College
900 Otay Lakes Road, Chula Vista, CA 91910

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