



DISABILITY VERIFICATION FOR CONTRACT RELEASE/EXEMPTION

Section I to be completed by student | **Section II** to be completed by physician or other certified/licensed professional

SECTION I- To be completed by student

First Name: _____ Last Name: _____

Date of Birth: _____ Red ID Number: _____

I authorize the release of the information requested on this Disability Verification Form to the Student Ability Success Center at San Diego State University.

Student Signature: _____ Date: _____

SECTION II- To be completed by physician or other certified/licensed professional (attach additional pages if necessary)

A. Diagnosis: _____

DSM or ICD Code(s): _____

This disability is: Permanent Temporary, expected to last through: _____
(specify length of time)

B. Describe the key features of a living environment that would address the student's disability-related needs:
Specific accommodation requests, e.g. single room, kitchen, etc., must include an explanation of what needs that accommodation would address.

C. Explain the reason(s) why on-campus housing accommodations would not be sufficient for the student's needs:

D. Additional Comments (optional): _____

Name of Professional: _____ (please print) Title/Specialty: _____

Certification or License #: _____ Email: _____

Address: _____ Phone: _____

I verify that the above information is complete and accurate to the best of my knowledge.

Signature of Professional: _____ Date: _____