SDSU | Student Affairs and Campus Diversity
Student Disability Services

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DISABILITY VERIFICATION FORM

Section I to be completed by student | **Sections II & III** 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 Student Disability Services at San Diego State University.

Student Signature: _____ Date: _____

SECTION II- To be completed by physician or other certified/licensed professional

A. Diagnosis: _____

DSM or ICD Code(s): _____

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

B. Briefly describe the functional limitations of the disability, effect of medications, etc. on the ability to meet class requirements (attach additional pages if necessary).

_____

_____

C. Functional Impact Assessment

0= None **1**= Mild/Moderate **2**= Severe

Major Life Activity	Degree of Impact	Major Life Activity	Degree of Impact
1. Caring for Oneself	☐ 0 ☐ 1 ☐ 2	14. Communicating	☐ 0 ☐ 1 ☐ 2
2. Talking	☐ 0 ☐ 1 ☐ 2	15. Learning	☐ 0 ☐ 1 ☐ 2
3. Hearing	☐ 0 ☐ 1 ☐ 2	• reading	☐ 0 ☐ 1 ☐ 2
4. Breathing	☐ 0 ☐ 1 ☐ 2	• writing	☐ 0 ☐ 1 ☐ 2
5. Seeing	☐ 0 ☐ 1 ☐ 2	• spelling	☐ 0 ☐ 1 ☐ 2
6. Walking/Standing	☐ 0 ☐ 1 ☐ 2	• quantitative reasoning	☐ 0 ☐ 1 ☐ 2
7. Lifting/Carrying	☐ 0 ☐ 1 ☐ 2	• math calculating	☐ 0 ☐ 1 ☐ 2
8. Sitting	☐ 0 ☐ 1 ☐ 2	• processing speed	☐ 0 ☐ 1 ☐ 2
9. Performing Manual Tasks	☐ 0 ☐ 1 ☐ 2	• memorizing	☐ 0 ☐ 1 ☐ 2
10. Eating	☐ 0 ☐ 1 ☐ 2	• concentrating	☐ 0 ☐ 1 ☐ 2
11. Interacting w/Others	☐ 0 ☐ 1 ☐ 2	• Listening	☐ 0 ☐ 1 ☐ 2
12. Sleeping	☐ 0 ☐ 1 ☐ 2	16. Working	☐ 0 ☐ 1 ☐ 2
13. Thinking	☐ 0 ☐ 1 ☐ 2	17. Other: _____	☐ 0 ☐ 1 ☐ 2

Please continue on to the next page for disability categories and your signature

SECTION III- To be completed by physician or other certified/licensed professional

Please complete all appropriate sub-sections that apply to your client/patient.

A. Perceptual Disability

Visual:

Visual Acuity Left: _____ Right: _____

Field Left: _____ Right: _____

Comments: _____

Hearing (Attach current audiogram if available):

dB Loss Left: _____ Right: _____

Comments: _____

B. Medical/Physical Disability

Briefly explain the nature of the medical/physical disability including diagnosis, medication effects, and their probable impact on the educational process.

_____

_____

C. Learning Disability

Briefly explain the nature of the learning disability and its functional limitations. Attach reports and/or test results, summary scores including computer scoring printouts, eligibility assessment and other comparable materials.

_____

_____

D. Neurological and/or Psychological Disability

Briefly explain the nature of the neurological and/or psychological disability and its probable impact on the educational process.

_____

_____

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

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: _____