

Disability Verification

The student named below may be eligible for special services at this college. In order to provide services we must have a verification of disability/diagnosis. The information you provide will be used for the sole purpose of determining eligibility for and authorization of accommodations at Los Angeles Trade Technical College

THIS SECTION TO BE COMPLETED BY STUDENT

Name (Print Last Name, First Name)	Student ID or SSN	Date of Birth
Address	City	Zip Code
Home Phone	Cell Phone	

I hereby authorize my health provider to release the information requested below.

Signature	Date
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THIS SECTION MUST BE COMPLETED BY THE LICENSED PROFESSIONAL

Please provide the following information IN FULL in order to help us determine reasonable educational accommodations to support this student:

1. Diagnosis: _____

If applicable, DSM IV Code and Severity: _____

2. Duration of Condition
 Permanent/Chronic
 If temporary, give estimated duration: _____

3. Condition is:
 Stable Observable
 Prone to exacerbations Non-observable

4. Prescribed Medication(s), Dosage & Side Effects:

5. Please describe how this/these condition/s substantially limits major life activities:

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.

Signature of Verifying Licensed Professional	Title/ & License #	Date
Print Name		
Address		
Phone	Fax	