



DISABILITY VERIFICATION FORM

California State University, Fresno
Services for Students with Disabilities
Henry Madden Library, Suite 1202
5200 N. Barton Ave., M/S 125 Fresno, CA 93740-8014
PHONE (559) 278-2811 FAX (559) 278-4214 VP (559) 278-8700

Student's Name _____

Student ID _____ Date of Birth _____

Address _____
City State Zip Code

Phone _____ Email _____

I authorize the following individual or organization to release the following information to Services for Students with Disabilities at California State University, Fresno:

Physician or Agency Name _____

Address _____ Phone _____
City State Zip Code

Student's Signature _____ Date _____

The California State University system requires written verification of disability in order to authorize academic for functional accommodations. **A person with a disability is defined by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 as "anyone with a physical or mental impairment that substantially impairs or restricts one or more major life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working."**

The student named above has applied to Services for Students with Disabilities for disability-related academic accommodations. To insure appropriate and timely accommodations, please provide the following information, test results and other diagnostic data as soon as possible.

1. Please specify the specific diagnosis:

Please complete the following for DSM IV diagnosis(es).

AXIS I : _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

2. Prognosis: Permanent Temporary (specify length of time) _____

3. Which major life activity does this individual's disability **substantially** limit:

- Hearing Vision Speech Breathing
- Walking Learning Manual Tasks Caring for one's self

4. Description of disability's functional impact in academic setting: _____

5. Current medication(s): _____

Side effects that may impact physical, perceptual and/or cognitive performance in an academic setting:

6. Recommended accommodations that this student may need to create an even experience and provide equal access: _____

I certify this individual experiences a disability as defined by the above:

Print name and Title

Signature

Date

Please return this form to the address above. ALL INFORMATION IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY. Please be aware, however, that under FERPA the documents are subject to review as a part of the education records of the office of Services for Students with Disabilities.