SCC DISABILITY VERIFICATION FORM

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Name: _____SCCID#: _____

Date of Birth: _____ Medical or other ID:_____

In order to receive disability-related services at Solano Community College/DSP, a verification of disability must be provided. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional: _____

Address: _____

Fax#: _____Phone#: _____

THIS SECTION MUST BE COMPLETED BY A LICENSED OR CERTIFIED PROFESSIONAL

Please provide the following information in full, in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis: _____

   DSM IV Code and Severity (if applicable) _____

2. Please describe how this condition substantially limits major life activities:

   _____

3. Condition is:
   - ❒ Stable
   - ❒ Prone to exacerbation

4. Duration of Disability:

   - ❒ Permanent/Chronic
   - ❒ Temporary (date of re-evaluation or estimated duration of disability) _____

Medical, and/or psychological documentation should be attached and returned to:

SCC Disability Services Program (Room 407)
4000 Suisun Valley Road
Fairfield, CA 94534-3197

Phone: (707) 864-7136
Fax: (707) 646-2068 / Attn: Sidne Parker
Email: dsp@solano.edu

I understand that the information provided by the verifying professional will become part of the student's record and may be released to the student upon their written request.

Verifying Professional Signature:_____Date:_____