

**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/ASC, 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 Accessibility Services Program (Room  
407) 4000 Suisun Valley Road  
Fairfield, CA 94534-3197

Phone: (707) 864-7136

Fax: (707) 646-2068 / Attn: Steven Ashby

Email: ASC@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:** \_\_\_\_\_