Disability Verification Form

The student below may be eligible for disability accommodations at California State University, Stanislaus. In order to determine eligibility and appropriate academic accommodations, CSUS must have verification of the diagnosis and of the resulting functional limitations. Information on this form will be used in confidence for the educational benefit of the student.

(To be completed by the student):

<table>
<thead>
<tr>
<th>First Name</th>
<th>Middle Initial</th>
<th>Last Name</th>
<th>Student ID</th>
<th>Phone Number</th>
<th>Date of Birth</th>
</tr>
</thead>
</table>

**This section to be completed by certificated professional**

1. Description and date of diagnosis(es): ________________________________

2. Describe the functional limitations and severity of impact on the student in an educational setting:

   Please note that accommodations will be determined based on documented, specific functional limitations.

   ________________________________

3. Describe any side effects and functional limitations resulting from treatments or medications: ________________________________

4. The above documented diagnosis is: _______ permanent/chronic _______ temporary until __________________________

   Month/Date/Year

Certifying Professional:

The documented diagnosis must be within the professional expertise and scope of practice of the certifying professional.

________________________________________________________________________________________

Name (typed or printed) ________________________________ Signature ________________________________

Title ________________________________ License # ________________________________

Address ________________________________ City ________________________________ State ________________________________ Zip Code ________________________________

Phone Number ________________________________ Fax Number ________________________________ Date ________________________________