LAS POSITAS COLLEGE

Disabled Student Programs & Services
3000 Campus Hill Drive | Room 1615, Livermore, CA 94551

DISABILITY VERIFICATION

In order to receive disability-related services at Las Positas College, students are required to provide documentation of their disability.

Student Information

Student Name: _____ W#: _____

Date of Birth: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Student Signature: _____ Date: _____

To Be Completed by Licensed Professional

Please provide the following information in full in order to help us determine reasonable educational accommodations to support this student. Please complete both sides.

1. Primary 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 and Side effects: _____

   _____

5. Functional limitations of condition and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student in the educational setting.) **Please check**:

   ☐ Speaking ☐ Hearing loss ☐ Visual acuity ☐ Limited ambulation

   ☐ Taking class notes ☐ Processing visual materials ☐ Providing written assignments

   ☐ Easily distracted ☐ Processing oral material ☐ Slow processing of information

   ☐ Poor concentration ☐ Caring for self

   ☐ Other: _____

   _____

(OVER →)

1. Secondary 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 and Side effects: _____

   _____

5. Functional limitations of condition and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student in the educational setting.) **Please check**:

   ☐ Speaking ☐ Hearing loss ☐ Visual acuity ☐ Limited ambulation

   ☐ Taking class notes ☐ Processing visual materials ☐ Providing written assignments

   ☐ Easily distracted ☐ Processing oral material ☐ Slow processing of information

   ☐ Poor concentration ☐ Caring for self

   ☐ Other: _____

   _____

I understand that the information provided with this form will become part of the student record subject to the Federal Family Education Rights and Private Act of 1974 and may be released to the student upon their written request.

Name of Licensed or Certified Professional: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

IMPORTANT: For questions about this form, please contact the Disabled Student Programs & Services (DSPS) office at 925.424.1510. Once completed, please scan and email it to lpc-dsps@laspositascollege.edu or fax it to 925.424.1515.