

Phone: (909) 384 - 4443 • Fax: (909) 889 - 7821

CONFIDENTIAL DISABILITY VERIFICATION

TO BE COMPLETED BY STUDENT						
Last:	: First:					
SSN# (Last four digits):	SBVC SID#					
Address:	City/Sta	te: Zip:				
Birth Date:	Telephone:					
TO BE COMPLETED BY CERTIFIED/LICENS	SED PROFESSIONAL					
Provider Name/Title (Print):						
Address:	CITY:	ZIP:				
TELEPHONE:	FAX:					
Please provide the following information	to help determine reasonable ed	ducational accommodations:				
1. Diagnosis:						
Date of Diagnosis: If Applicable: Current Clinical DSM 5 and/or ICD 10 Indicate how side effects of medication Communicating/Speaking Easily Distracted Extremity Weakness Hearing Loss Other Level of hearing loss: (Attach Audiogramuse) Hearing loss interferes with the service of th	Diagnostic Code(s): on affects student: Limited Ambulation Planning Classes Poor Concentration Processing Information Mild Moderate Se	☐ Processing Oral Material ☐ Processing Visual Material ☐ Taking Class Notes ☐ Vision				
	ation devices in an educational/v	ocational setting.				
Visual impairment - I certify this client	t to be visually impaired accordir	ng to the following criteria:				
A visual field of 20 degrees ofAny progressive eye diseaseAn uncorrectable vision prob	olem or reduced visual stamina su her visual acuity is limited to 6/2	ection. e of the above in the next two years. uch that the applicants functions 1 or less in the better eye after				
2. Is the student/patient currently under	r your care?	■ No				

	☐ Eating☐ Reading	_	☐ Caring for s☐ Lifting☐ Speaking	☐ Moving☐ Standing	g □ Concentrating/Learning □ Performing manual tasks □ Walking
4. Condit		☐ Prone to Ex		☐ Stable	
5. Does it	: impact any c	of the following?	? (Optional)	☐ Forming/Executing Plans	•
				☐ Memory	☐ Social Interaction
	on of disabilit	•	7.		
⊔Perr	nanent/Chron	IIC (→ Temporary Ur	ntil Date:	
8. Please setting:	provide any	additional infor	mation/comme	nts helpful in determining a	accommodations in an educational
Educatio	nal, medical,	and/or psycholo	ogical document	tation should be attached a	nd returned to:
College:	San Bernard	lino Valley Colle	ge		
	Student Acc	essibility Service	es (SAS)		
	701 South N	lount Vernon A	venue		
	San Bernard	lino, CA 92410			
Email:	sbvcsas@va	lleycollege.edu			
Fax:	(909) 889-78	321			
The infor	mation provid	ded by you regar	-		ed as confidential and will be disclosed
The infor	mation provid	ded by you regar	-		
The infor by the Cc	mation provid	ded by you regar necessary for as	-		quested services or accommodations.