



CONFIDENTIAL DISABILITY VERIFICATION

TO BE COMPLETED BY STUDENT

Last: _____ First: _____

SSN# (Last four digits): _____ SBVC SID# _____

Address: _____ City/State: _____ Zip: _____

Birth Date: _____ Telephone: _____

TO BE COMPLETED BY CERTIFIED/LICENSED PROFESSIONAL

Provider Name/Title (Print): _____

Address: _____ CITY: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

Please provide the following information to help determine reasonable educational accommodations:

1. Diagnosis: _____

Date of Diagnosis: _____

If Applicable:

Current Clinical DSM 5 and/or ICD 10 Diagnostic Code(s): _____

Indicate how side effects of medication affects student:

- Communicating/Speaking, Easily Distracted, Extremity Weakness, Hearing Loss, Limited Ambulation, Planning Classes, Poor Concentration, Processing Information, Processing Oral Material, Processing Visual Material, Taking Class Notes, Vision, Other

Level of hearing loss: (Attach Audiogram) Mild Moderate Severe Profound

- Uses aided hearing, Hearing loss interferes with client's learning, Would benefit from amplification devices in an educational/vocational setting.

Visual impairment - I certify this client to be visually impaired according to the following criteria:

- A visual acuity of 6/21 (20/70) or less in the better eye after correction, A visual field of 20 degrees or less in the better eye after correction, Any progressive eye disease with a prognosis of becoming one of the above in the next two years, An uncorrectable vision problem or reduced visual stamina such that the applicants functions throughout the day as if his/her visual acuity is limited to 6/21 or less in the better eye after correction.

2. Is the student/patient currently under your care? Yes No

