ORANGE COAST COLLEGE
DISABLED STUDENT PROGRAMS AND SERVICES (DSPS)

CONFIDENTIAL

Disability Verification (DV)

2701 Fairview Road, P.O. Box 5005 Costa Mesa, CA 92626-5005 Phone: (714) 432-5807 FAX: (714) 432-5557

Student Name: _____

Student OCC ID#: C_____ **Birth Date** *(optional)*: _____

I hereby authorize release of the information below to Orange Coast College DSPS:

_____ _____

Student's Signature Date

VERIFYING PROFESSIONAL: *The following diagnostic information is to be completed by a licensed clinician to determine existence of a disability(s) and will be used for OCC Disabled Student Programs and Services (DSPS) eligibility.*

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

_____

_____

List all disabilities and include information describing the student's current condition: _____

_____

Functional/Educational Limitations: Indicate how the disability, condition and/or side effects of medication affect the 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 _____

Impact of disability on functional/educational limitations? ❒ Mild ❒ Moderate ❒ Severe

Please list other limitations/information helpful in determining accommodation(s) in an educational setting:

_____

_____

Duration of Condition: ❒ Permanent/Chronic

❒ Temporary (date of re-evaluation or estimated duration of disability) _____/_____/_____

Condition is: ❒ Stable ❒ Observable

❒ Prone to Exacerbations ❒ Non-Observable

Please complete if relevant for student: 1) *Visual Acuity:* Left _____ Right _____

2) *Audiogram:* Please attach most recent documentation to this form.

3) *Exercise (e.g. cardio, stretching, weight-training and/or aquatics) that is*:

Contraindicated: _____

Recommended: _____

This form must be completed and signed by a *Licensed Certified Professional (e.g.* M.D., Psychologist, Psychiatrist).

_____ _____

Signature of Verifying Licensed/Certified Professional Print Name

_____

Professional Title (e.g. MD, PhD., etc.) License/Certification # Phone/Fax

_____

Street Address City State Zip Code

The Coast Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Student Programs and Services (DSPS) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state/federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232 (g)). The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

Rev. 06/28/2019