CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO
Services to Students with Disabilities

RESPECT • ABILITY • ACCESS • DIGNITY

Disability Verification Request

This form is to be completed in full by a licensed professional.

Student Name: _____ DOB: _____

Diagnoses (Include ICD/DSM-V codes): **Date:**

1. _____ _____
2. _____ _____
3. _____ _____

Severity: ☐ Mild ☐ Moderate ☐ Severe ☐ Partial Remission ☐ Residual State

Condition: ☐ Permanent ☐ Temporary until _____ **Date of last visit:** _____

List Current Medications:

Medication	Dosage	Frequency	Patient Reported Side Effects

Describe how the disability limits major life activities:

_____

_____

State the impact and specific functional limitations relating to academic performance:

_____

_____

_____

Signature of Licensed Professional: _____ Date of Verification: _____

Print Name/Title: _____ License Number: _____

Address: _____

Phone Number: _____

Received

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