Disability Verification Request
Services to Students with Disabilities
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO

Student Name:____ DOB#:____________________

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

Diagnoses (Including ICD/DSM-IV 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:

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____

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

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____
____

____
Signature of Licensed Professional Date of Verification

____
Print Name/Title License Number

____
Address Phone Number

5500 University Parkway, UH183, San Bernardino, CA 92407
Phone 909.537.5238 ~ Fax 909.537.7090

Received