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:

_____

_____

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

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

Received