



## DISABILITY VERIFICATION PACKET

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**On the Disability Verification Form included in this packet,  
the Student Information section is interactive and can be filled out online**

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### INSTRUCTIONS TO STUDENT:

In order to receive disability-related services at Los Angeles Valley College, a student must submit a Disability Verification Form, documenting a physical and/or psychological disability. The form must be completed and signed by a licensed/certified professional qualified to diagnose and treat the conditions.

- STEP 1. Print this packet which includes 4 pages: Instructions, Form, Letter, and Disability Definitions.
  - STEP 2. Complete the Student Information section on the Disability Verification Form [page 2] and be sure to sign where indicated.
  - STEP 3: Provide this packet to your treating professional.
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DISABILITY VERIFICATION FORM

STUDENT INFORMATION TO BE COMPLETED BY STUDENT

NAME: \_\_\_\_\_ SSN/ID #: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_
ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_
PHONE #: \_\_\_\_\_ CELLPHONE #: \_\_\_\_\_ EMAIL: \_\_\_\_\_

I hereby authorize my health provider to release the information requested below. (student signature): \_\_\_\_\_

TO BE COMPLETED BY PROFESSIONAL

Name of Licensed or Certified Professional: (please print clearly) \_\_\_\_\_
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_
Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Please provide the following information in full in order to qualify the student for eligibility and help us determine reasonable educational and physical accommodations:

1. Diagnosis: (Required, please print clearly)

A: \_\_\_\_\_ B: \_\_\_\_\_

If Applicable, DSM Code: \_\_\_\_\_ Severity: [ ] Moderate [ ] Severe [ ] Residual/Remission

2. This condition substantially limits the following major life activities: (Required)

- [ ] Moving [ ] Walking [ ] Manual Tasks [ ] Bending [ ] Standing [ ] Lifting [ ] Breathing [ ] Concentrating
[ ] Seeing [ ] Reading [ ] Hearing [ ] Communicating [ ] Sleeping [ ] Eating [ ] Caring for Self [ ] Writing

3. Does it impact any of the following? (Optional)

- [ ] Stamina [ ] Forming/Executing Plans [ ] Social Interaction [ ] Overcoming Obstacles [ ] Memory

4. List other limitations/information helpful in determining accommodations in an educational setting:(Required, please print)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Condition is: (Optional) [ ] Stable [ ] Prone to exacerbation

6. Prescribed Medications: (Optional)

7. Duration of Disability: (Required)

[ ] Permanent/Chronic [ ] Temporary

If disability is temporary, select one: [ ] Less than 45 day [ ] 45 days or greater

Expected duration: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that the information provided will become part of the student record subject to the Federal Family Education Rights and Privacy Act of 1974 and may be released to the student on their written request.

Signature: \_\_\_\_\_ Title/Lic. # \_\_\_\_\_ Date: \_\_\_\_\_



## DISABILITY VERIFICATION FORM

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### LETTER TO TREATING PROFESSIONAL

Date: \_\_\_\_\_

Dear Health Professional:

The patient named on the attached Los Angeles Valley College **Disability Verification Form** has requested that his/her disability be verified. This documentation is for the purpose of making him/her eligible for special courses or disability-related services and is required by the California Educational Code, Title V.

Eligible conditions and the authorized health professionals who may verify them and sign the Disability Verification Form are described on the attached "Disability Definitions and Documentation", page 4.

#### INSTRUCTIONS:

- 1. Items 1 – 5--must be completed.**
- 2. Item 2—at least one "MAJOR LIFE ACTIVITY"** limitation must be checked in order for the student to be eligible.
- 3. Form must be COMPLETED and SIGNED by the health professional** qualified to diagnose and treat the specific condition. (See attached "*Disability Definitions and Documentation.*")
- 4. Please return this by FAX or Mail**, unless requested otherwise by student.  
(*Attach any medical, psychological and/or educational documentation.*)

**LOS ANGELES VALLEY COLLEGE  
SERVICES FOR STUDENTS WITH DISABILITIES  
5800 FULTON AVENUE  
VALLEY GLEN, CA 91401-4096  
FAX (818) 778-5775**

This completed form must be returned to the Services for Students with Disabilities' Office before the student can receive disability – based accommodations.

Thank you for your prompt attention on behalf of your patient. If you have questions, please call our office at (818) 947-2681.

Sincerely,

Services for Students with Disabilities  
Los Angeles Valley College



DISABILITY VERIFICATION PACKET

DISABILITY DEFINITIONS AND DOCUMENTATION

Eligibility for disability services is based on an individual's condition which must: 1. Fall within the diagnostic categories listed below. AND: 2. Impair a major life activity, and 3. Pose an educational limitation for which accommodation is required and appropriate.

Los Angeles Valley College uses the information requested on the Disability Verification Form for the purpose of determining a student's eligibility to receive authorized special services provided by Services for Students with Disabilities. The Definitions here per the State of California Administration Code, Title 5, Section 56032 to 56044.

Table with 4 columns: Disability, Community College Definition\*, Qualified Professionals, and Important Notes. Rows include Physical Disability, Visual Impairment, Mobility, Orthopedic Impairment, Hearing impairment, Deaf, Hard of Hearing, Speech and Language Impairment, Learning Disabilities, Acquired Brain Impairment, Developmentally Delayed Learner, Psychological Disability, ADD/ADHD, and Other Disabilities.

For further information on qualifying disabilities and/or signature and documentation requirements, call the Services for Students with Disabilities Office at 818-947-2681. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure.