Cypress College

Disability Support Services

Disability Verification

CONFIDENTIAL

for DSS office use only
☐Referred by DD
Date____________

Student's Name ______________________ Student ID # ______________ Date of Birth ____/____/____

Address ____________ City ______ State ______ Zip Code ______ Phone Number ______

Please provide the following information in order to help us determine the appropriate educational accommodations to support this student:

1. Diagnosis DSM code, if applicable
   1)________________________________ Mild ☐ Moderate ☐ Severe ☐
   2)________________________________ Mild ☐ Moderate ☐ Severe ☐
   3)________________________________ Mild ☐ Moderate ☐ Severe ☐

2. Functional limitations of disability and/or medications. Please check:
   - ☐ Speaking
   - ☐ Limited ambulation
   - ☐ Visual acuity
   - ☐ Poor concentration
   - ☐ Hearing loss
   - ☐ Taking class notes
   - ☐ Completing written assignments
   - ☐ Slow processing of information
   - ☐ Processing oral material
   - ☐ Processing visual materials
   - ☐ Easily distracted
   - ☐ Other ____

3. Prescribed medications and dosage: ____

4. The above-mentioned disability(ies) is/are:
   ☐ Permanent / Chronic
   OR
   ☐ Temporary – Must provide estimated duration of disability: ______________________

5. This condition is: ☐ Stable ☐ Prone to exacerbation

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request. Form must be signed by a qualified professional (medical practitioner or psychologist) licensed to diagnose such condition/disability.

Signature ______________________ ______________ ______________
Verifying Licensed Professional Title Date

Name: (printed) ____

Address ____

Phone ______________________ FAX ______________________

PLEASE RETURN OR FAX TO:

CYPRESS COLLEGE (DSS)
9200 Valley View Street, Cypress, California 90630-5897
Phone (714) 484-7104 ◈ Video Phone (657) 777-4208 ◈ FAX (714) 484-6045
North Orange County Community College District

Revised 09/08/2015

To be completed by DSS Certificated Professional ONLY

I hereby certify this student is eligible for DSS services and/or accommodations based on observation and interaction with the student.

DSS Counselor Signature ____ Date __________________

LD Specialist ____ Date __________________

DSS Director ____ Date __________________