Services for Students with Disabilities

Verification of Disability Form

California State University, Bakersfield has received notice from our student indicating that they have a condition or disability that requires an accommodation in the academic setting. To process this request and provide academic accommodations, additional information is needed from you as their identified licensed treatment provider.

All medical information shall be kept confidential and maintained as part of their educational record and protected under the Family Educational Rights and Privacy Act (FERPA) and/or the Health Insurance Portability and Accountability Act (HIPAA) . First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations.

The California State University System requires written verification of disability as defined below in order to authorize educational or functional accommodations:

The Rehabilitation Act of 1973 and the Americans with Disabilities Act define a disabled person as:

> *"Anyone with a physical or mental impairment that substantially impairs or restricts one or more major life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."*

For a student to receive services from our office due to a disability, the accompanying form must be completed. There must be a ***specific diagnosis*** or ***identified symptoms*** related to their condition, as well as ***functional limitation***. The disability must limit one or more life activities. If this is not marked on the form, the student will not qualify for services.

Student Information

Name: ____ CSUB ID#: ________________________

Address: ____

City: ________________________________ State: __________ Zip Code: ______________________

Phone: (_______) ____________________ CSUB Email: ____________________________________

Student Signature: ______________________________________ Date Signed: ___________________

REMAINDER OF FORM TO BE COMPLETED BY ***LICENSED MEDICAL PROVIDER***

Disability or Condition Information

1. Describe the (a) nature, (b) severity, and (c) duration of the student's disability or condition. If the disability or condition is temporary, indicate the end date of the temporary disability or condition.

2. Does the disability or condition substantially limit a major life activity? Yes No
   If yes, please check the major life activity or activities that apply:

Bending	Learning	Sitting
Breathing	Lifting	Sleeping
Caring for Self	Performing Manual	Speaking
Concentrating	Tasks	Standing
Eating	Reaching	Thinking
Hearing	Reading	Walking
Seeing	Interacting w/ Others	Working

Other (describe):

3. Functional Limitation: How does this student's disability or condition limit their ability to have equal access to the curriculum or campus community?

4. Disability effects on academic performance:

Task Initiation Decreased	Fatigue
Concentration Impaired	Impaired Fine Motor Ability
Comprehension	Slowed Processing Speed

Other:

5. Disability effects on Executive Functioning: **N/A**

Planning & Time Management
Attention (Focus/Concentration)
Difficulty with Organization
Problem Solving
Other:
Decision Making
Working Memory
Self-Control/Regulating Emotions

6. Prognosis: Permanent Temporary (specify length): ________________

7. Please attach any test results or other treatment data which may help us serve this student (optional)

Licensed Practitioner Information

Name: ______________________________________

License Number: ______________________________ Type of License: ____________________

Address: ____

City: ____________________________ State: __________ Zip Code: ____________________

Phone Number: (_______) ____________________ Fax Number: (_______) ____________________

Provider Signature: __________________________________ Date Signed: ________________

This form will not be accepted without signature from practitioner