CALIFORNIA STATE UNIVERSITY
BAKERSFIELD

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: _____ Zip Code: _____

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