Verification of Disability

Disability Support Services

333 South Twin Oaks Valley Road
San Marcos, CA 92078
Office: (760) 750-4905
FAX: (760) 750-3445
Email: dss@csusm.edu

I. Release of Information

To: _____
(Name of physician/specialist/agency who can provide verification of disability)

Address: _____

City: _____ State: _____ Zip: _____

For the purposes of determining reasonable accommodations, I authorize the release of the medical information and all other information requested on this form to California State University San Marcos and the CSU Chancellor's Office in order for me to seek and obtain reasonable accommodations for a disability. This authorization will remain in effect for one year or until_____. I may revoke this authorization in writing by submitting revocation to Disability Support Services.

Student Name or Authorized Representative (please print): _____

Signature: _____ Date: _____

Date of Birth: _____ Student ID#: _____

II. Verification of Disability

A student with a disability (whether a mental disability or physical disability) is a person enrolled at California State University San Marcos who has a verified disability which limits one or more major life activities, as defined in California Government Code 12926 and California Education Code 66260.5. Specifically, having a physical or mental condition that limits a major life activity which includes physical, mental, and social activities (such as walking, talking, seeing hearing) and working.

By signing below, I verify that the above-named student meets the definition of a "student with a disability" by reason of the following disability. If the disability is mental health in nature, please provide the DSM-5 classification:

1. Diagnosis: _____
2. DSM-5 and/or ICD-11 Code(s) and Severity: _____
3. Limitations to Major Life Activities: _____
4. Duration of Disability: ☐ Permanent/Chronic ☐ If temporary, give estimated duration/date of re-evaluation: _____
5. Disability is:
   ☐ Stable ☐ Observable ☐ Prone to exacerbations ☐ Non-observable
6. Side effects of treatment that impact student's ability to perform Major Life Activities: _____

_____

_____

7. Functional limitations of condition and/or medication (e.g. the ways in which the diagnosis and/or side effects of medications affect the student.) **Please check:**

☐ Speaking	☐ Hearing loss	☐ Processing oral material
☐ Limited ambulation	☐ Taking class notes	☐ Processing visual materials
☐ Visual acuity	☐ Providing written assignments	☐ Easily distracted
☐ Poor concentration	☐ Slow processing of information	
☐ Other: _____		

_____

I certify that the above referenced client/patient has a physical or mental impairment that limits one or more of the major life activities as defined by the Americans with Disabilities Act, California Government Code 12926 or California Education Code 66260.5.

Title of Agency: _____

Printed Name/Title/ & Lic #: _____ Phone: (_____) _____

Signature: _____ Date: _____