IRVINE VALLEY COLLEGE

DISABLED STUDENTS PROGRAM & SERVICES VERIFICATION OF DISABLILITY

The student named below may be eligible for special classes/services at Irvine Valley College.

Students with disabilities are persons with exceptional needs enrolled at a community college who, because of professionally verified physical, communication, learning, acquired brain injury, developmental delayed learning, or psychological disability cannot benefit from regular class activities and services provided by the community college without specific additional support services and programs. Title V, Article 3, Section 56030-56044.

Title 5 Section 56006 of the Education Code for the State of California states that every student with a disability applying for Disabled Student Program services or accommodations must provide documentation from an appropriate agency or certified or licensed professional. This documentation must verify a current educational limitation affecting one or more major life activity and be directly related to every classroom service or accommodation being requested.

Name of Student _____
(Please Print) First MI Last

Birthdate _____ Social Security # _____

I authorize you to release from your records any information regarding my medical or health conditions and/or educational development to Irvine Valley College. All records maintained by DSPS personnel pertaining to students with disabilities are protected from disclosure and are subject to all other requirements for handling of student records. Participation by students with disabilities in the DSPS program is entirely voluntary, however, services and accommodations specialized for disabilities are provided and managed through the DSPS office. Receiving support services or specialized instruction does not preclude a student from also participating in any course, program or activity offered by the college.

Student Signature _____ Date _____

Name of Physician or Specialist who can provide verification of disability:

_____
(Please Print) First Last

_____
Street Address Phone Number

_____
City State Zip

To the Physician/Specialist/Agency:

Please check all of the following that apply to the student's disability. It would also be beneficial to us if you would list the degree, progressive factor and the limiting effects of the disability. Such documentation may be provided in the space below or by forwarding test results or other verification. We are required by California Education Code to have such information on file and would appreciate your assistance in completing the following:

_____**Mobility** _____**Visual (corrected acuity)** → _____left _____right

_____**Speech** _____**Hearing (corrected decibel levels)** → _____left _____right _____**ABI**

_____**DDL** _____**Psychological** → _____Current DSM Code _____**LD** (appropriate testing required)

_____**Other Health**: Explain _____

Medication (related to disability) _____

Side Effects _____

Diagnosis _____

Progressive Factor _____ Temporary _____
Active, Arrested, Chronic, Acute, etc. Less than 12 months

Brief description of functional/educational limitations _____

_____ _____
SIGNATURE of Physician/Specialist → → (PRINT NAME) Title (PLEASE PRINT))

_____ _____
License # Date