IRVINE VALLEY COLLEGE | DISABILITY SUPPORT PROGRAMS FOR STUDENTS

Verification of Disability (VOD)

The student named below may be eligible for accommodations and services at IVC through DSPS.

First Name: _____ **Last Name** _____ **Mi:**_____

Student ID #: _____**DOB:** _____**Phone #:** _____

Name of Physician or Specialist authorized to complete the verification of disability form:

First Name: _____**Last Name:** _____

Phone #: _____ **Fax #:** _____

I authorize the above physician or specialist to release information regarding my medical or health conditions and/or educational development to IVC.

Student's Signature: _____**Date:** _____

To be completed by Physician/Specialist:

To assist IVC's DSPS in determining reasonable educational accommodations to the student above, please complete the information below:

Diagnosis:

☐ Permanent ☐ Temporary - Date of expected recovery: _____

- ☐ ADHD
- ☐ Autism
- ☐ Intellectual Disability (ID)
- ☐ Acquired Brain Injury (ABI)
- ☐ Learning Disability → Provide appropriate assessment scores
- ☐ Mobility Impairment: _____
- ☐ Deaf/ Hard of Hearing → Corrected decibel levels: _____left _____right
- ☐ Visual Impairment → Corrected acuity: _____left _____right
- ☐ Mental Health →DSM Code: _____
- ☐ Other: _____

Prescribed Medication (s) and Side Effects: _____

Functional limitations: the ways in which the diagnosis affects the student in the educational environment

☐ Ability to maintain stamina
☐ Behavior
☐ Focus and attention
☐ Hearing
☐ Mobility
☐ Oral Communication
☐ Physical regulation
☐ Processing information
☐ Sitting for extended periods of time
☐ Social communication/ social interaction
☐ Vision
☐ Other: _____

Name: _____Signature: _____

Title: _____ License #: _____ Date: _____