CHSU
CALIFORNIA HEALTH SCIENCES UNIVERSITY

Disability Verification Form

Department of Student Affairs/Accessibility Services

2500 Alluvial Avenue, Clovis, CA 93611

Directions: Students should fill in and sign the top half of the form then deliver the form to the student's treating health professional and have them complete the bottom half of the form. Once completed, the form must be submitted to Accessibility Services.

Student's Name: _____

Date of Birth: _____

Address: _____
City *State* *Zip Code*

Phone: _____ Email: _____

I authorize the following individual or organization to release the following information to California Health Science University ("CHSU"), Department of Student Affairs:

Medical Professional or Agency Name: _____

Address: _____
City *State* *Zip Code*

_____
Student Signature *Date*

CHSU requires written verification of disability in order to authorize academic or functional accommodations. A person with a disability is defined by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 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."

The student named above has applied to services and/or for disability-related academic accommodations. To insure appropriate and timely accommodations, please provide the following information, test results and other diagnostic data as soon as possible.

Please specify the specific diagnosis:

Prognosis: ☐ Permanent ☐ Temporary (specify length of time)_____

Which major life activity does this individual's disability **substantially** limit:

☐ Hearing ☐ Vision ☐ Speech ☐ Breathing ☐ Walking ☐ Learning

☐ Manual Tasks ☐ Caring for one's self

Does the disability affect the following academic activities?

Reading Speed ☐	Reading Comprehension ☐	Spelling ☐	Writing Papers ☐
Math ☐	Taking Notes ☐	Memory ☐	Attention/Concentration ☐
Study Skills ☐	Time Management ☐	Organization ☐	Test Taking ☐

Please explain how the above activities are affected by the student's disability:

Current medication(s): _____

Side effects that may impact physical, perceptual and/or cognitive performance in an academic setting:

Suggestions for accommodations to provide equal access for this student:

I certify this individual experiences a disability as defined by the above:

_____

Print name and Title

_____ _____

Signature *Date*

Please return this form to the address above. ALL INFORMATION IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY. Please be aware, however, that under the federal Family Educational Rights and Privacy Act, the documents are subject to review as a part of the education records of the Student Affairs Department.