OFFICE FOR STUDENTS WITH DISABILITIES

5151 State University Drive, Los Angeles, CA 90032
PH: 323-343-3140 FAX:323-343-6429
Email: osd@calstatela.edu

SECTION I: To be completed by student

Student Name: (Please TYPE or PRINT clearly)_____ DOB: _____

I am requesting academic support services through the Office for Students with Disabilities at Cal State LA which requires current and comprehensive documentation of my disability and functional limitations. Please respond to the following questions as soon as possible and return to OSD by e-mail or fax. I authorize the Office for Students with Disabilities at Cal State LA to contact you if clarification is needed.

Student Signature:_____ Date:_____ CIN #: _____

SECTION II: To be completed by professional only

DISABILITY VERIFICATION FORM

Please provide the following information regarding the student above to help us determine reasonable educational and physical accommodations:

1. Diagnosis: _____

If applicable: DSM V Code: _____ Severity: ❒ Moderate ❒ Severe ❒ Remission

❑Visual Impairment (attach prescription) ❑Hearing (attach audiogram)

2. This condition substantially limits the following major life activities: (examples include sleeping, eating, writing, etc.)

3. List current functional limitations imposed by the disability to determine accommodations:

4. How long has the patient been under your care, and is the individual currently in treatment with you?

5. Duration: ❑Permanent (lasting longer than 6 months) ❑Temporary – End Date:_____

6. Date of Diagnosis:_____ Date of last contact:_____

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Name of Physician or Certified/Licensed Professional: _____

Title/Specialty:_____ **License or Certification #:**_____

Address:_____ **City:**_____

State:_____ **Zip Code:**_____ **Phone Number:** _____

I verify that the above information is complete and accurate to the best of my knowledge and certify that I am not related to this student.

Signature of Physician or Certified/Licensed Professional:_____ **Date:** _____