

MOORPARK COLLEGE

DISABILITY VERIFICATION



Accessibility Coordination Center & Educational Support Services
7075 Campus Road, Moorpark, CA 93021
Phone: (805) 378-1461 Fax: (805) 378-1594

Date _____

Student _____ Social Security # _____ - _____ - _____ DOB _____

This student may be eligible for special services at Moorpark College. In order to provide these services we must have a verification of disability as defined on the reverse side of this form. **The information you provide will become part of the student record and may be released to the student upon their written request.** Please provide all of the following information in order to help determine reasonable educational accommodations to support this student. Any other pertinent information that may help us to better serve this student's educational needs will be appreciated. Available educational, medical, and/or psychological diagnostic documentation should be attached and returned to the college at the above address. A signed "Consent for Release of Information" form is attached and may be retained for your records.

THIS SECTION MUST BE COMPLETED BY A LICENSED OR CERTIFIED PROFESSIONAL

1. Primary Disability _____
(For Specific Learning Disabilities, please see attached form)
2. DSM IV Code and severity (if applicable) _____
3. Describe how this condition substantially limits any major life activity. **Please address areas relating to attention, concentration, and mental processing needed for academic progress, if applicable.**

4. The disability is: stable variable prone to exacerbation
5. The disability is: permanent/chronic temporary (estimated duration) _____
6. Secondary Disability (if applicable) _____
(For Specific Learning Disabilities, please see attached form)

Verifying Professional Signature _____ Date _____

Name (please print) _____ Title _____

Address _____

Phone# _____ FAX# _____ OFFICE STAMP HERE: (required)

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and contact information of the original diagnostician.

Name: _____ Address: _____

Phone: _____ Fax: _____