FOLSOM LAKE COLLEGE/EL DORADO CENTER
DSP&S DISABILITY VERIFICATION
Disabled Student Programs & Services

MED

*DATE:*_____

MEDICAL VERIFICATION FOR:

Name: _____ **Medical Record#:**_____ **D.O.B**:_____

Address: _____ **SS/ID#:** _____

Phone #:_____

In order to receive disability-related services at Folsom Lake College/EDC a verification of disability must be provided. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional:_____

Address:_____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

Please provide the following information in full in order to help determine reasonable educational accommodations to support this student:

1. Diagnosis: _____
2. DSM IV Code and Severity (if applicable) _____
3. Please describe how this condition substantially limits major life activities:_____
   _____
4. Condition is: θ ☐ Stable θ☐ Prone to exacerbation
5. Duration of Disability: θ☐ Permanent/Chronic
   θ☐ Temporary (date of re-evaluation or estimated duration of disability _____

Educational, medical, and/or psychological documentation should be attached and returned to:

θ☐ College—Attn: Disabled Student Programs & Services, Folsom Lake College, 100 Clarksville Road, Folsom, CA 95630

θ☐ Student—See Address Above

I understand that the information provided by the verifying professional will become part of the student record, and may be released to the student upon their written request.

Verifying Professional Signature:_____ **Date:** _____

If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis :_____