CHSU
CALIFORNIA
HEALTH SCIENCES
UNIVERSITY

Student Disability Verification Form

Office of Student Affairs

Please return this form to the address below. **ALL INFORMATION IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY.** Please be aware that under FERPA, these documents are subject to review as a part of the education records of the Office of Student Affairs.

Last Name	First Name	M. I.	Student ID#
Date of Birth	Email Address	Telephone Number	

I authorize the following individual or organization to release the following information to California Health Sciences University College of Pharmacy Office of Student Affairs:

Physician or Agency Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Student Signature _____ Date _____

California Health Sciences University requires written verification of disability in order to authorize academic 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 about has applied to the Office of Student Affairs for disability-related academic accommodations. To ensure appropriate and timely accommodations, please provide the following information, test results, and other diagnostic data as soon as possible.

1. Please specify the specific diagnosis:

_____

Please complete the following for DSM IV diagnosis(es):

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

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

3. Which major life activity does this individual's disability substantially limit?

☐ Hearing ☐ Vision ☐ Speech ☐ Breathing
☐ Walking ☐ Learning ☐ Manual Tasks ☐ Caring for one's self

4. Description of disability's functional impact in academic setting:

5. Current medication(s): _____

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

6. Recommended accommodations that this student may need to create an even experience and provide equal access:

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

Print Name and Title

Signature Date

For Office of Student Affairs Use Only

Date Received: _____ Received By: _____

www.CHSU.org
120 N. Clovis Avenue, Clovis, CA 93612 • (559) 325-3600 • Fax: (559) 473-1487

Print Form