VICTOR VALLEY COLLEGE ACCESS Resource Center
DISABILITY VERIFICATION FORM

The student named below may be eligible for services at Victor Valley College. In order to provide services we must have verification of disability.

Students: Return completed form with the application packet to:
ACCESS Resource Center
Victor Valley College
18422 Bear Valley Rd Victorville, CA 92395

Student Name: _____ **Student ID#:** _____
Last First M.I.

Address: _____ **Phone #:** _____
Street

_____ **Date of Birth:** _____
City State Zip

Please provide the following information in full in order to help determine reasonable educational accommodations to support this student. (Medical Professional to complete)

1. **PRIMARY DIAGNOSIS**:_____ ICD 10 Code: _____ DSM V Code: _____
   - Which major life activities are limited by this condition?
     ☐ Vision ☐ Hearing ☐ Mobility ☐ Memory ☐ Concentration ☐ Other: _____
     Please describe:_____
   - If applicable, how do side effects of prescribed medications substantially limit major life activities:
     _____
   - Condition is: ☐ Stable ☐ Prone to exacerbations
   - Duration of Disability: ☐ Permanent/Chronic ☐ Temporary – (Give estimated date of recovery): _____
   - Specify current severity: ☐Mild ☐Moderate ☐Severe ☐Profound

2. **SECONDARY DIAGNOSIS**: _____ ICD 10 Code: _____ DSM V Code: _____
   - Which major life activities are limited by this condition?
     ☐ Vision ☐ Hearing ☐ Mobility ☐ Memory ☐ Concentration ☐ Other: _____
     Please describe: _____
   - If applicable, how do side effects of prescribed medications substantially limit major life activities:
     _____
   - Condition is: ☐ Stable ☐ Prone to exacerbations
   - Duration of Disability: ☐ Permanent/Chronic ☐ Temporary – (Give estimated date of recovery): _____
   - Specify current severity: ☐Mild ☐Moderate ☐Severe ☐Profound

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

Signature: _____ Title & Lic. #: _____ Date: _____
(Certifying Professional)

Name (please print): _____ Phone #: _____

Address:_____
Street City State Zip

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:_____

A PHOTO COPY OF THIS IS AS VALID AS THE ORIGINAL

Updated 11/15/17