COLLEGE OF THE CANYONS

Academic Accommodation Center (AAC) 26455 Rockwell Canyon Road, Santa Clarita, CA 91355

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Verification of Disability

The student named below may be eligible for support services at College of the Canyons. In order to provide services, we must have a verification of disability.

Name_____ Student ID #_____
Last First - M.I.

Please provide the following information in full:

1. Description of disability(ies), including Diagnosis:_____

_____

_____

_____

2. For Psychiatric or Psychological Diagnosis:_____DSM V Code

3. Functional Limitations (i.e., limited ambulation, visual acuity, degree of hearing loss, etc.):_____

_____

_____

_____

4. Prescribed medications (and dosage) that adversely affect the student in the classroom:_____

_____

_____

5. The above mentioned disability(ies) is/are: ☐ Observable ☐ Not Observable
☐ Permanent/Chronic Temporary: ☐ Less than 45 days ☐ 45 to 90 days

Educational / Functional Limitations

Within the educational environment of this college, this student may have difficulty in the following areas:

☐ Producing class notes, homework assignments, and other written requirements
☐ Seeing or processing visually presented classroom materials
☐ Hearing or processing lectures, student discussions, and other orally presented information
☐ Taking tests in a traditional manner (i.e., extended time, distraction reduced environment, etc.)
☐ Completing course requirements without group tutoring
☐ Planning appropriate classes
☐ Interacting with college instructors, counselors, and other college personnel
☐ Transversing significant distances in a timely manner
☐ Climbing stairs and successfully negotiating other physical barriers on campus
☐ Using certain college facilities, equipment, and materials
☐ Other_____

It is understood that information furnished on this form is provided with a written release from the above named student and will be used in confidence for the educational benefit of this student.

Name:_____Title:_____
Print or Type Name- Certifying Professional

Signature:_____ Date:_____

Please verify this form with your official stamp.