LOS MEDANOS COLLEGE
DISABLED STUDENTS PROGRAMS & SERVICES
DISABILITY VERIFICATION/AUTHORIZATION TO RELEASE INFORMATION

THIS SECTION MUST BE COMPLETED BY THE STUDENT

In order to receive disability-related services at Los Medanos College a verification of disability must be provided.

Name: _____ Soc. Sec/I.D. #: _____

Address: _____

Date of Application: _____ Telephone #: _____ D.O.B.: _____

I, _____, authorize the release of information from _____

student signature agencies/school

regarding my disability(ies) to Los Medanos College. All information will be kept confidential and maintained as a part of my records with the Los Medanos College Disabled Students Programs & Services (DSP&S) office. I authorize the release of information to include one or more of the following records identified below or that the professional designated below complete this form:

Name of Licensed or Certified Professional: _____ Phone #: _____

Address: _____ Fax #: _____

THIS SECTION MUST BE COMPLETED BY A LICENSED OR CERTIFIED PROFESSIONAL

Please provide the following information in full. This will help to determine reasonable educational accommodations that will 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: ☐ Stable ☐ Prone to exacerbation
5. Duration of Disability: ☐ Permanent/Chronic
   ☐ Temporary _____(date of re-evaluation or estimated duration of disability)

Any educational, medical or psychological documentation requested below should be attached and returned to:
DSP&S Program, Los Medanos College, 2700 E. Leland Road, Pittsburg, CA 94565

- ☐ Diagnosis of disability signed by an appropriate medical practitioner or psychologist.
- ☐ Psychological testing and evaluation results.
- ☐ Vocational Rehabilitation Plan
- ☐ Individual Education Plan (IEP)
- ☐ Detailed results of assessment, psychological, or medical testing that led to the diagnosis.

Other:_____

I understand that the information provided by the verifying professional becomes part of the student's record & may be released to the student upon their request.

_____ _____
Signature of verifying licensed or certified professional *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 below:

_____

Name Address

The Contra Costa Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disabled Students Programs and Services (DSP&S) Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232 (g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Educational Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000, et seq.