California State University Chico
Accessibility Resource Center

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California State University, Chico
Student Services Center 170
Chico, California 95929-0726
Voice or Relay (530) 898-5959
Fax (530) 898-4411
www.csuchico.edu/arc

Disability Verification

The student named below may be eligible for services and accommodations offered through Accessibility Resource Center at **California State University, Chico**. To determine eligibility, verification and documentation of the student's disability must clearly demonstrate that **they have** one or more functional limitations in the academic environment. Please note that the determination of actual services and accommodations will be made by Accessibility Resource Center.

TO BE COMPLETED BY STUDENT

Last Name: First Name:

Date of Birth: Student ID Number:

I authorize the release of the information requested below to Accessibility Resource Center at California State University, Chico:

Student's Signature: Date:

TO BE COMPLETED BY A LICENSED PROFESSIONAL QUALIFIED TO ASSESS THE NATURE AND EXTENT OF THE SPECIFIC DISABILITY:

Mobility	**Blind/Visual Impairment**	**Autism Spectrum Disorder**
ADHD	**Medical/Health Impairment**	**Deaf/Hearing Impairment**
Acquired Brain Injury	**Psychological/Mental Health**	**Other:**

*Note: "Test Anxiety" is not a disability. This form may be insufficient **to** document Learning Disabilities.*

Specific Diagnosis:

Anticipated Duration of Disability:

Permanent
Temporary until **(end date must be indicated)**

DSM-5 Classification(s) (If applicable)

Code: Description:

Please check all areas you feel will be impacted by the diagnosis in an educational setting:

- Reading
- Writing
- Spelling
- Quantitative Reasoning
- Math Calculating
- Talking
- Hearing
- Breathing
- Seeing
- Walking/Standing
- Lifting/Carrying
- Processing Speed
- Memorizing
- Concentrating
- Listening
- Communicating
- Sitting
- Performing manual tasks
- Eating
- Interacting with Others
- Sleeping

Clear statement of functional limitations, which this diagnosis creates for the student in the educational setting (e.g. easily distracted, tires easily, may need to stand during class lecture):

Current services and/or medications prescribed to mitigate impact of the disability/illness, if applicable:

Legibly Print name of verifying professional:

Signature of Professional: License #:

Phone: Fax: Date:

Return this completed form to our office as soon as possible so this student may begin to receive appropriate academic accommodations. Please include any verifying documents from your files (e.g. audiogram, medical records, etc.).

All sections are required. Rev. 6-2023