Accessibility Resource Center
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 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
ADHD
Acquired Brain Injury
Blind/Visual Impairment
Medical/Health Impairment
Psychological/Mental Health
Autism Spectrum Disorder
Deaf/Hearing Impairment
Other:

"Test Anxiety" is not a disability.

Please note: This form is insufficient to document Learning Disabilities.

Specific Diagnosis:

This is a temporary disability with an end date of:

DSM-5-TR Classification(s) (if applicable)

Code: **Description:**

Please check all areas in which the diagnosis may impact the student within 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

Provide a 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):

List current services or medications prescribed to mitigate impact of the disability or illness, if applicable:

Legibly print **name of verifying professional:**

Professional License Type: **License #:**

Signature of Professional: **Date:**

Phone: **Fax:**

Return this completed form to our office as soon as possible so this student may begin to receive appropriate academic accommodations. Completed forms may be faxed to 530-898-4411. Please include any verifying documents from your files (e.g., audiogram, medical records, etc.).

All **sections are required.**