DRC

DISABILITY VERIFICATION

RIVERSIDE CITY COLLEGE

CONFIDENTIAL

Date: ____________________

The student named below may be eligible for services at RIVERSIDE CITY COLLEGE. In order to provide services we must have verification of disability as defined on the reverse side of this sheet.

Please send completed form to: Disability Resource Center
Riverside City College
4800 Magnolia Avenue, Riverside, Ca. 92506

951-222-8060
FAX: 951-222-8059

Name: ____ Social Security #: ______________________
Last First M

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.

1. **PRIMARY DIAGNOSIS**:________________________________ ICD 10 Code: ________ DSM V Code: _________
   - Which of the following conditions substantially limits major life activities?
     ☐ 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): ____________________

2. **SECONDARY DIAGNOSIS**: ________________________________ ICD 10 Code: ________ DSM V Code: _________
   - Which of the following conditions substantially limits major life activities?
     ☐ 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): ____________________

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.

Signature: ________________________________ Title: ______________________ 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