Disability Verification Form

IMPORTANT: Students are responsible for providing documentation verifying their disability to the Bob Murphy Access Center (BMAC) office.* A BMAC Disability Specialist will review documentation to determine eligibility for support services and/ or reasonable accommodations. Completion of this form does not guarantee eligibility for services.

The student named below may be eligible for academic accommodations provided through the Bob Murphy Access Center (BMAC) at California State University Long Beach (CSULB). In order to provide services, BMAC must have verification of disability on file with the Support Services office. Please be assured that the information provided by you will remain *confidential* and will not be released to third parties unless instructed to do so by the student

Please Note: Student medical records supplied to this office constitute "educational records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

A person with a disability is defined by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 as "*anyone with a physical or mental impairment that substantially impairs or restricts one or more major life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working.*"

Part 1: Student Information: (to be completed by student)

Date of Birth: _____ ID: _____

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ CSULB E-mail Address: _____

Important Notice: Once the student has signed the form, the forms in part 1 will be locked and can not be edited. Please make sure the information provided is correct before signing.

I authorize the release of the information requested on this Disability Verification Form to the Bob Murphy Access Center at California State University Long Beach.

Date: _____ Student Signature: _____

REMAINDER OF FORM TO BE COMPLETED BY PRACTITIONER *(Feel free to attach additional information, documentation or reports)*

Part 2: Diagnostic Information: *(to be completed by practitioner - please check all that apply)*

This disability is: ○ Temporary (lasting 6 months or less) End date: _____

○ Permanent

☐ Attention Deficit Hyperactivity Disorder (ADD/ADHD): ○ Hyperactive ○ Inattentive ○ Combined Type

☐ Learning Disability: ☐ Reading ☐ Writing ☐ Mathematics ☐ Dyslexia

☐ Visual Limitation

☐ Acquired Brain Injury/Traumatic Brain Injury

☐ Communicative Disability

☐ Deaf or Hard of Hearing

☐ Autism Spectrum Disorder

☐ Asperger's Syndrome

☐ Psychological/Psychiatric:

☐ Seizure Disorder

☐ Chronic Health Condition: _____

☐ Other: _____

☐ Mobility limitation: Utilize: ☐ Wheelchair ☐ Scooter ☐ Walking Aid

☐ Anxiety Disorder ☐ Panic Disorder ☐ Clinical Depression ☐ Bipolar Disorder ☐ Eating Disorder

☐ PTSD - Post Traumatic Stress Disorder ☐ OCD - Obsessive Compulsive Disorder

☐ Schizoaffective Disorder ☐ Schizophrenia

☐ Other: _____

** Disability verification and documentation also includes pregnancy-related information*

Primary Diagnosis:

Secondary Diagnosis:

Functional Limitations: (to be completed by practitioner ***please check all that apply***)

Please check the following activities which are significantly limited by the above stated disability(ies) and/or side effects of medication. Indicate the level of severity as mild, moderate or severe for the identified disability(ies).

1 = *Mild* 2= *Moderate* 3 = *Severe*

Psychological:

N/A	Affect
N/A	Coping with Stress
N/A	Awareness

Communication:

N/A	Receptive Language
N/A	Expressive Language
N/A	Interacting with Others

Sensory:

N/A	Hearing
N/A	Visual

Other:

N/A	Breathing
N/A	Stamina
N/A	Alertness
N/A	

Learning:

N/A	Attention
N/A	Concentration Information
N/A	Processing Memory
N/A	Writing
N/A	Reading
N/A	Math Reasoning
N/A	
N/A	
N/A	

Mobility:

N/A	Ambulation
N/A	Coordination
N/A	Fine Motor
N/A	Range of Motion
N/A	Balance
N/A	Sitting
N/A	Lifting
N/A	Standing
N/A	Stooping
N/A	Reaching

Medications: (to be completed by practitioner)

	Name	Dosage	Side Effects
1:			
2:			
3:			

Additional Comments (attach additional documentation if needed):

Name of Certifying Professional:

License #: Title:

Organization:

Address: City: State Zip Code

Important Notice: Once the practitioner has signed the form, the forms in part 2 will be locked and can not be edited. Please make sure the information provided is correct before signing.

Date: Professional's Signature:

Please submit completed form to:

Bob Murphy Access Center ~ SSC-110

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