Disability Verification

Allan Hancock College
Learning Assistance Program
800 S. College Drive A-304 Santa Maria, CA 93454
PH: (805) 922-3966 ext. 3274 FAX: (805) 922-3556

Last Name	First Name	M.I.	DOB
Address	City	Zip	H Number

1. Diagnosis: _____
   If applicable, DSM Diagnosis & Severity: _____
   (Reference Disability Definitions from California Title 5 regulations on reverse)
2. Duration of condition:
   - ☐ Permanent/Chronic
   - ☐ Temporary, give estimated duration:
3. Condition is:
   - ☐ Stable
   - ☐ Prone to exacerbations
   - ☐ Observable
   - ☐ Non-observable
4. Educational/Functional limitations (Please check all that apply):
   - ☐ Speaking/communicating
   - ☐ Limited ambulation
   - ☐ Visual acuity/seeing
   - ☐ Poor concentration
   - ☐ Hearing
   - ☐ Taking tests in a traditional manner
   - ☐ Taking class notes
   - ☐ Producing written assignments
   - ☐ Processing of information
   - ☐ Reading
   - ☐ Processing oral material
   - ☐ Processing visual material
   - ☐ Easily distracted
   - ☐ Memory
   - ☐ Other:
5. Please list any academic adjustments or accommodations that are recommended:

_____
_____
_____
_____
_____

Signature of Verifying Professional

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Signature: _____ Title/License #: _____

Name (printed): _____

Address: _____

City: _____ State/Zip: _____

Phone: _____ Date: _____