IRVINE VALLEY COLLEGE | DISABLED STUDENTS PROGRAMS & SERVICES

Verification of Disability (VOD)

The student named below may be eligible for accommodations and services at IVC through DSPS.

First Name: _____**Last Name:** _____**Mi:**_____

Student ID #: _____**DOB:** _____**Phone #:** _____

Name of Physician or Specialist authorized to complete the verification of disability form:

First Name: _____**Last Name:** _____

Phone #: _____**Fax #:** _____

I authorize the above physician or specialist to release information regarding my medical or health conditions and/or educational development to IVC.

Student's Signature: _____**Date:** _____

To be completed by Physician/Specialist:

To assist IVC's DSPS in determining reasonable educational accommodations to the student above, please complete the information below:

Diagnosis:

☐ Permanent ☐ Temporary - Date of expected recovery: _____

- ☐ ADHD
- ☐ Autism
- ☐ Intellectual Disability (ID)
- ☐ Acquired Brain Injury (ABI)
- ☐ Learning Disability → Provide appropriate assessment scores
- ☐ Mobility Impairment: _____
- ☐ Deaf/ Hard of Hearing → Corrected decibel levels: _____left _____right
- ☐ Visual Impairment → Corrected acuity: _____left _____right
- ☐ Mental Health →DSM Code: _____
- ☐ Other: _____

Prescribed Medication (s) and Side Effects: _____

Functional limitations: the ways in which the diagnosis affects the student in the educational environment

☐ Speaking	☐ Hearing loss	☐ Processing oral material
☐ Limited ambulation	☐ Taking class notes	☐ Processing visual materials
☐ Visual acuity	☐ Providing written assignments	☐ Easily distracted
☐ Poor concentration	☐ Slow processing of information	

☐ Other: _____

Name: _____Signature: _____

Title: _____License #: _____Date: _____