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

Ability to maintain stamina
☐ Behavior
Focus and attention
Hearing
Mobility
Oral Communication
☐ Physical regulation
Processing information
Sitting for extended periods of time
Social communication/ social interaction
Vision
Other:

Name: Signature:

Title: License #: Date: