CRAFTON HILLS COLLEGE
STUDENT ACCESSIBILITY SERVICES

Mail, fax, email or deliver to:
Crafton Hills College
Student Accessibility Services 11711 Sand Canyon Rd. Yucaipa, CA 92399 Ph: (909)389-3325 Fax: (909)794-3684
email: chc_sas@craftonhills.edu

Verification of Student Disability

THIS FORM MUST BE COMPLETED IN ENTIRETY BY A CERTIFIED OR LICENSED MEDICAL PROFESSIONAL

*If this form is not filled out in completeness and/or correctly, all provided information will be considered void.

I, _____ (Name) _____ (Title), verify that the patient listed below has a disability which limits one or more major life or academic activities.

Patient Name: _____ (Last), _____ (First) Date of Birth: ____ (Mo) / ____ (Day) / _____ (Year)

This patient has the following primary disability (***HAND INITIAL*** to verify):

____ Acquired Brain Impairment
____ Learning Disability
____ Speech / Language
____ Intellectual Disability
____ Mobility Impairment
____ Visual Impairment
____ Deaf / Hard of hearing
____ Autism / Asperger's
____ ADD / ADHD
____ Mental Health: DSM-IV AXIS I & II Diagnosis and Code(s): _____
____ Other: _____

This disability is (circle one): permanent / temporary
observable / non-observable

The above disability causes the following educational limitations (***HAND INITIAL*** all that apply):

____ Gross motor skills
____ Fine motor skills
____ Attention
____ Concentration
____ Loosely-structured learning environment
____ Long-term memory
____ Short-term memory
____ Other: _____
____ Walking
____ Sitting for extended times
____ Standing for extended times
____ Using dominant hand
____ Processing visual information
____ Processing auditory information
____ Receptive language

Recommended services or academic accommodations: _____

X _____ **Signature ("Wet/Hand" Signature Required)** _____ **License No.** _____ **Date**

Name and Title _____
Place of Practice _____
Address _____
_____
Contact Phone _____

ENDORSEMENT STAMP REQUIRED