# TO BE FILLED OUT BY MEDICAL OR OTHER CERTIFIED PROFESSIONAL

The student named below is applying for support services at Palomar College, through the Disability Resource Center (DRC). In order to provide services, we must have verification of disability. It is understood that information furnished on this form will be used in confidence for the educational benefit of this student.

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**STUDENT SECTION:**

Name: ______________________________________________ Last Four of SS#______________

Palomar College Student ID: ______________________________ DOB: _______/_______/________

Name of Medical Provider/Verifying Professional: ____________________________________________

Phone #:________________________________ Fax #: _____________________________________

**I hereby authorize the information requested below be released to the Palomar College DRC.**

_________________________________________ _____________________________

**Student's Signature** **Date**

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**VERIFYING PROFESSIONAL SECTION:** Please list all disabilities and include information describing the student's disabling condition.

1. **Diagnosis/description of disability(ies) or conditions. Provide DSM/ICD code if applicable:**

_______________________________________________________________________________

_______________________________________________________________________________

2. **Functional and/or educational limitations: (i.e., limited ambulation; visual acuity; degree of hearing loss; cognition impairment, etc.)**

_______________________________________________________________________________

_______________________________________________________________________________

3. **Condition is:** _______**Stable** _______**Prone to Exacerbation**

4. **Duration of disability(ies) is/are:**

_______**Permanent/Chronic** _______**Temporary (Est. Duration of Disability):**______________

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_______________________________________________________________________________

**Signature of Licensed/Certified Professional** **Print Name**

_______________________________________________________________________________

**Professional Title (i.e., MD, Ph.D., etc,)** **License/Certification #** **Date**

**Please fax to Palomar College DRC, (760) 761-3509 or email dsps@palomar.edu**

| **DRC Office Only** | **Received By (initial):** ______________ | **Date:** _____/______/______ |
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