CALIFORNIA STATE UNIVERSITY BAKERSFIELD | Services for Students with Disabilities

# VERIFICATION OF DISABILITY FORM

Student's Name: ______________________________ Date: ______________

CSUB ID#______________________ Date of Birth: ____________________

Address: ______________________________________________________
Street Address City State Zip

Cell Phone: ( ) ____________ E-Mail: ______________________________

I authorize release of the following information to Services for Students with Disabilities, at California State University, Bakersfield, by the provider named below:

______________________________ ( ) ______________________
Name Phone Number

______________________________________________________
Street Address City State Zip

Student's Signature: ______________________________ Date: __________________

**Attention Provider**

1. The above named student has applied for academic accommodations through the Office of Services for Students with Disabilities at CSUB. Please provide the following information, with test results or other diagnostic data, in order to verify that this student is qualified to receive appropriate accommodations.

2. The California State University System requires written verification of disability as defined below in order to authorize educational or functional accommodations:

   The Rehabilitation Act of 1973 and the Americans with Disabilities Act define a disabled person as:

   > *"Anyone with a physical or mental impairment that substantially impairs or restricts one or more major life activities, such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."*

3. For a student to receive services from our office due to a disability, the accompanying form must be completed. There must be a ***specific diagnosis***, as well as ***functional limitation***. The disability must **limit one or more life activities.** If this is not marked on the form, the student will not qualify for services.

Rev. 04/22

**Student's Name:** ______________________________________ DOB: ______________

Last First

1) Specific diagnosis of disability: ______________________________________

2) Functional Limitations (How does the diagnosis affect the student?): ______________________________________

3) Prescribed medications & dosage: ______________________________________

4) Prognosis: Permanent Temporary (Specify length) ______________________

5) Indicate areas life that are affected by the student's disability:

| Hearing | Breathing | Learning/Reading |
|---|---|---|
| Seeing | Speaking | Working |
| Walking | Manual Tasks | Caring for one's self |

6) Comments: ______________________________________

______________________________ Provider's Name (Please print)

______________________________ Phone Number

______________________________ Provider's Signature

______________________________ Date

Return this form to:

Services for Students with Disabilities
California State University, Bakersfield
9001 Stockdale Highway, 55 SA
Bakersfield, CA 93311
Phone (661) 654-3360

OR FAX (661) 654-2171

The designated Section 504 Compliance Officer/ADA Coordinator is Marcus Brown, J.D., Director of Equity, Inclusion, and Compliance. Mr. Brown is located in the President's Office, BDC E100. He may be reached at 661-654-2713, or mbrown59@csub.edu