ORANGE COAST COLLEGE

ACCESSIBILITY RESOURCE CENTER (ARC)

CONFIDENTIAL

Disability Verification (DV)

2701 Fairview Road, Costa Mesa, CA 92626 Phone: (714) 432-5807 E-mail: occarc@cccd.edu

Student Name: ____

Student OCC ID#: C________________________ **Birth Date** *(optional)*: ______________

I hereby authorize release of the information below to Orange Coast College ARC:

______________________________ ______________

Student's Signature Date

VERIFYING PROFESSIONAL: *The following diagnostic information is to be completed by a licensed clinician to determine existence of a disability(s) and will be used for OCC ACCESSIBILITY RESOURCE CENTER (ARC) eligibility.*

Current Clinical DSM 5 and/or ICD 10 Diagnostic Code(s) *(if applicable)*: ______________________________

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List all disabilities and include information describing the student's current condition: ____________________

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Functional/Educational Limitations: Indicate how the disability, condition and/or side effects of medication affect the student.

- ❒ Communicating/Speaking
- ❒ Easily Distracted
- ❒ Extremity Weakness
- ❒ Hearing Loss
- ❒ Limited Ambulation
- ❒ Planning Classes
- ❒ Poor Concentration
- ❒ Processing Information
- ❒ Processing Oral Material
- ❒ Processing Visual Material
- ❒ Taking Class Notes
- ❒ Vision
- ❒ Other ____

Impact of disability on functional/educational limitations? ❒ Mild ❒ Moderate ❒ Severe

Please list other limitations/information helpful in determining accommodation(s) in an educational setting:

____

____

Duration of Condition: ❒ Permanent/Chronic

❒ Temporary (date of re-evaluation or estimated duration of disability) _____/______/_____

Condition is: ❒ Stable ❒ Observable

❒ Prone to Exacerbations ❒ Non-Observable

Please complete if relevant for student: 1) *Visual Acuity:* Left ______________ Right ________________

2) *Audiogram:* Please attach most recent documentation to this form.

3) *Exercise (e.g. cardio, stretching, weight-training and/or aquatics) that is*:

Contraindicated: ____

Recommended: ____

This form must be completed and signed by a *Licensed Certified Professional (e.g.* M.D., Psychologist, Psychiatrist).

______________________________ ______________________________

Signature of Verifying Licensed/Certified Professional Print Name

____

Professional Title (e.g. MD, PhD., etc.) License/Certification # Phone/Fax

____

Street Address City State Zip Code

The Coast Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Accessibility Resource Center (ARC). Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state/federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232 (g)). The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.

Rev. 03/20/2023