



Student Affairs & Enrollment Management
Disability Services for Students
(707) 664-2677 Fax: (707) 664-3330
TDD: (707) 664-2958

1801 East Cotati Avenue
Rohnert Park, CA 94928-3609
www.sonoma.edu/dss

DISABILITY VERIFICATION FORM

SECTION 1 – To be Filled Out by Applicant

Name: _____
Address: _____ City/Zip: _____
Day Phone: _____ Date of Birth: _____
Physician/Appropriate Professional: _____
Address: _____ City/Zip: _____
Phone: _____ Kaiser #: _____

I authorize the release of the information requested on this form to the Disabled Student Services office, Sonoma State University. All information will remain confidential unless authorized by the student.

Applicant's Signature Date

SECTION 2 – To be Filled Out by Physician/Professional

A. COMPLETE FOR CLIENTS WITH MOBILITY/PHYSICAL DISABILITY:

Diagnosis/Functional Limitations: _____

Comments and recommendations: _____

B. VISUAL IMPAIRMENT: Visual Acuity Left _____ Right _____
Field Left _____ Right _____

Diagnosis/Functional limitations: _____

Comments and recommendations: _____

C. HEARING IMPAIRMENT: db Loss (Please attach recent audiogram)

Left _____ Right _____

Diagnosis/Functional limitations: _____

Comments and recommendations: _____

D. SPEECH IMPAIRMENT:

Diagnosis/Functional limitations: _____

Comments and recommendations: _____

SECTION 3 – COMPLETE FOR ALL CLIENTS

Please check appropriate:

_____ (1) The applicant is/will be temporarily disabled until: _____

OR

_____ (2) The applicant has an on-going/permanent disability.

Briefly describe the functional limitations of the disability, effect of medications, etc., on ability to meet course requirements and academic accommodations: _____

Name of certifying professional: (Please print)

Name:

Title:

Address:

Telephone Number:

I verify that the above information is complete and accurate to the best of my knowledge.

Signature of certifying professional

Date

NOTE TO CERTIFYING PHYSICIAN/PROFESSIONAL: You must provide reliable evidence with respect to the severity, duration, and nature of the patient's/client's condition sufficient to establish the existence of a disability under the AMERICAN'S WITH DISABILITIES ACT (ADA) and/or IDEA.

ATTENTION DOCUMENTING PROFESSIONALS: According to FERPA, records provided to the DSS Office are subject to disclosure to the student and their authorized designee. Please do not provide to the DSS copies of any of your medical or psychological records that you feel should not be viewed by your client.

Please call Disability Services for Student (707) 664-2677 if you have any questions.