



Disability Verification Form



IMPORTANT: Students are responsible for providing documentation verifying their disability to the Bob Murphy Access Center (BMAC) office. A BMAC Disability Specialist will review documentation to determine eligibility for support services and/ or reasonable accommodations. Completion of this form does not guarantee eligibility for services.

The student named below may be eligible for academic accommodations provided through the Bob Murphy Access Center (BMAC) at California State University Long Beach (CSULB). In order to provide services, BMAC must have verification of disability on file with the Support Services office. Please be assured that the information provided by you will remain *confidential* and will not be released to third parties unless instructed to do so by the student

Please Note: Student medical records supplied to this office constitute "educational records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

A person with a disability is defined by the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 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."

Part 1: Student Information: (to be completed by student)

Date of Birth: _____ ID: _____

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ CSULB E-mail Address: _____

Important Notice: Once the student has signed the form, the forms in part 1 will be locked and can not be edited. Please make sure the information provided is correct before signing.

I authorize the release of the information requested on this Disability Verification Form to the Bob Murphy Access Center at California State University Long Beach.

Date: _____ Student Signature: _____

REMAINDER OF FORM TO BE COMPLETED BY PRACTITIONER (Feel free to attach additional information, documentation or reports)

Part 2: Diagnostic Information: (to be completed by practitioner - please check all that apply)

This disability is: Temporary (lasting 6 months or less) End date: _____

Permanent



Attention Deficit Hyperactivity Disorder (ADD/ADHD): Hyperactive Inattentive Combined Type

Learning Disability: Reading Writing Mathematics Dyslexia

Visual Limitation

Acquired Brain Injury/Traumatic Brain Injury Seizure Disorder

Communicative Disability Chronic Health Condition:

Deaf or Hard of Hearing Other:

Autism Spectrum Disorder Mobility limitation: Utilize: Wheelchair Scooter Walking Aid

Asperger's Syndrome

Psychological/Psychiatric: Anxiety Disorder Panic Disorder Clinical Depression Bipolar Disorder Eating Disorder

PTSD - Post Traumatic Stress Disorder OCD - Obsessive Compulsive Disorder

Schizoaffective Disorder Schizophrenia

Other:



Primary Diagnosis:

Secondary Diagnosis:

Functional Limitations: (to be completed by practitioner *please check all that apply*)

Please check the following activities which are significantly limited by the above stated disability(ies) and/or side effects of medication. Indicate the level of severity as mild, moderate or severe for the identified disability(ies).

Mobility:

<u>1 = Mild</u>		<u>2 = Moderate</u>	<u>3 = Severe</u>		
Psychological:			Learning:		
Affect			Attention		
Coping with Stress			Concentration Information		
Awareness			Processing Memory		
			Writing		
Communication:			Reading		
Receptive Language			Math Reasoning		
Expressive Language					
Interacting with Others					
Sensory:					
Hearing			Ambulation		
Visual			Coordination		
Other:			Fine Motor		
Breathing			Range of Motion		
Stamina			Balance		
Alertness			Sitting		
			Lifting		
			Standing		
			Stooping		
			Reaching		

Medications: (to be completed by practitioner)

	Name	Dosage	Side Effects
1:			
2:			
3:			

Additional Comments (attach additional documentation if needed):

Name of Certifying Professional:

License #:

Title:

Organization:

Address:

City:

State

Zip Code

Important Notice: Once the practitioner has signed the form, the forms in part 2 will be locked and can not be edited. Please make sure the information provided is correct before signing.

Date:

Professional's Signature:

Please submit completed form to:

Bob Murphy Access Center ~ SSC-110
California State University Long Beach
1250 Bellflower Blvd.
Long Beach, CA 90840
or via e-mail at **bmac@csulb.edu**
or via fax at (562) 985-4529



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