CAL POLY
Student Affairs
Disability Resource Center

Disability Resource Center, Bldg 124-119
California Polytechnic State University
San Luis Obispo, CA 93407
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Provider Verification of Disability Form

In order for us to provide appropriate accommodations and services, we need to establish that this individual has a disability that limits one or more of the major life activities. **Note: Please attach a copy of any supportive report or test results that would be helpful in determining eligibility and appropriate services.**

Today's Date: _____ **Date of Last Appointment:** _____

Student's Name: _____
Last First M.I

Disability/Diagnosis:

Level of Severity: ☐ **Mild** ☐ **Moderate** ☐ **Severe**

Quality of Life: ☐ **Excellent** ☐ **Good** ☐ **Fair** ☐ **Poor**

Duration: ☐ **Permanent** ☐ **Temporary Until Date:** _____

Please describe any prescribed medications, their side effects and/or any potential impact the medications may have on academic performance:

Functional Limitations: Please check the level of limitation you believe this student experiences in the college environment as a result of their disability. Check only those boxes that apply.

1: Slightly Limited 2: Moderately Limited 3: Substantially Limited

	1	2	3			1	2	3
Caring for Oneself	☐	☐	☐		Writing	☐	☐	☐
Talking	☐	☐	☐		Spelling	☐	☐	☐
Hearing	☐	☐	☐		Quantitative Reasoning	☐	☐	☐
Breathing	☐	☐	☐		Math Calculating	☐	☐	☐
Seeing	☐	☐	☐		Processing Speed	☐	☐	☐
Walking/Standing	☐	☐	☐		Memorizing	☐	☐	☐
Lifting/Carrying	☐	☐	☐		Concentrating	☐	☐	☐
Sitting	☐	☐	☐		Listening	☐	☐	☐
Performing Manual Tasks	☐	☐	☐		Executive Functioning	☐	☐	☐
Eating	☐	☐	☐		Other (ex: scheduling/organizing):			
Working	☐	☐	☐			☐	☐	☐
Interacting with Others	☐	☐	☐			☐	☐	☐
Sleeping	☐	☐	☐			☐	☐	☐
Reading	☐	☐	☐			☐	☐	☐

Additional Comments: Is there anything else we should know about this student (e.g., specific symptoms, time-of-day needs, flare-ups that might affect academic performance)?

Note: Qualified diagnosing professionals are appropriately licensed psychologists, neurologists and in some instances family practice physicians. The diagnosing professional must have expertise in the differential diagnosis of the documented disability, follow established best practices in the field and not be related to the patient.

Provider Name: _____ License Number: _____

Signature: _____

Address: _____

Phone: _____ Fax: _____ Email: _____