IMPERIAL VALLEY COLLEGE

Disability Support Program and Services
380 E. Aten Road, Imperial, CA 92251
Phone: (760) 355-6434 Fax: (760) 355-6434
Email: dsps@imperial.edu

To whom it may concern:

You are receiving this form because the student/ client who is attending or planning to attend Imperial Valley College has applied for the Disability Support Program and Services. We are required to obtain written verification from an appropriate agency and/or physician regarding the nature of the student's condition that results in educational limitations.

You have been identified by this student as someone who can verify his/her condition. Attached you will find the eligibility verification form for you to complete, and return to us. If your verification is based on a report from a physician, psychologist, or other specialist, a copy of the report must be attached.

Should you require further information regarding this request, please feel free to call us at (760) 355-6434. Thank you for your assistance and for taking the time from your schedule to provide us with this information.

Sincerely,

Wendy Prewett
DSPS Director

IMPERIAL VALLEY COLLEGE

Eligibility Verification

Imperial Valley College uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by DSPS.

Student Information:

G#: _____

Name: _____

Phone: _____

Date of Birth: _____

Section below is to be completed by the licensed or certified professional.

1. Description of diagnosis: _____
2. DSM/ICD and severity (if applicable): _____
3. Date of diagnosis: _____
4. Please check any applicable functional/educational limitations:
   ☐ memory loss ☐ cognitive processing ☐ problem solving ☐ easily distracted ☐ poor concentration
   ☐difficulty focusing for extended periods of time ☐ difficulty formulating and executing plan of action
   ☐ difficulty overcoming unexpected obstacles ☐ panics in unfamiliar situations ☐ loss of visual acuity
   ☐ degree of hearing loss
   ☐ Other: _____
5. Prescribed medications and dosage: _____
6. The above mentioned condition(s) is/are:
   ☐Permanent/Chronic ☐Temporary: Days_____Weeks_____Months _____
7. Condition is: ☐ Prone to Exacerbation ☐Stable
8. Accommodations recommended:_____
9. This condition is: ☐Observable ☐ Not Observable

If this form is completed by someone other than the professional who made the diagnosis, the name and address of the person who made the diagnosis should also be listed below.

Signature of Licensed/ Certified Professional	Print Name	Address

Professional Title (i.e. MD, Ph.D., etc.)	License/Certification #	Phone	Date

Return to student or Fax to: (760) 355-6434 or Email: dsps@imperial.edu or Mail to: 380 E. Aten Rd, Imperial, CA 92251

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 state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including FERPA (20 U.S.C.1232 (g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a note). The information on this form is being collected pursuant to the California Education Code Sections 67310-67312, and 84850, and California Code of Regulations, Title 5, Section 54000.