



Imperial Valley College
Mel Wendrick Access Center

Disabled Student Program and Services
380 E. Aten Road, Imperial, CA 92251
Phone (760) 355-6313 Fax (760) 355-6132
Email: dsps@imperial.edu

To Whom It May Concern:

_____ is a student who is attending or planning to attend
(Student's Name)

Imperial Valley College. He/She has applied for one or more special services as a direct result of his/her disability. We are required to obtain written verification from an appropriate agency and/or physician regarding the nature of the student's disability, resultant educational limitations, and accommodation needs.

You have been identified by this student as someone who can verify his/her disability. Attached you will find the signed release for disability verification 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,

Norma Nava

Norma Nava,
Coordinator, IVC Disabled Student Program and Services



Disability Support Services Disability Verification

This section to be completed by the student.

Name: _____
Last
First
M

Address: _____
Street
City
State
Zip Code

Cellphone: _____ Phone: _____ Birthdate: _____

I hereby authorize the release of any confidential information to verify my disability in accordance with Section 504 of the Federal Rehabilitation Act and the Americans with Disabilities Act. A copy of this document is as valid as the original. This authorization shall remain in effect until revoked in writing by the undersigned.

Student's self-identified disability: _____

 Student's Signature Date

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. 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 the Family Educational Rights and Privacy Act (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), providing your social security number is voluntary. 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.

This section is to be completed by the licensed or certified professional.

1. Description of disability(ies): _____
2. DSM/ICD and severity (if applicable): _____
3. Date of diagnosis: _____
4. Please check any applicable functional/educational limitations:
 writing memory 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 (Please Describe): _____
5. Prescribed medications and dosage: _____
6. The above mentioned disability(ies) is/are:
 Permanent/Chronic Temporary: Days _____ Weeks _____ Months _____
7. Accommodations recommended: _____
8. This disability 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) 355-6132 or Email: dsp@imperial.edu or Mail to: 380 E. Aten Rd, Imperial, CA 92251