Services for Students with Disabilities– Diagnosis Verification Form (PRIVATE)

PENINSULA COLLEGE

This section to be completed by student:

Last Name _____ First Name _____ Middle Initial _____

PC Student ID _____ Date of Birth _____

This section to be completed by appropriate medical or mental health provider:

Is the above named student currently under your care? YES | NO

Diagnosis (with DSM/ICD codes):

Treatment plan, including medication and assistive tools:

Current impact and functional limitations, with treatment (if receiving), including in an academic setting. Please address prognosis, if relevant.

Is this condition impacted by environmental or situational conditions? YES | NO
If yes, please describe these conditions and how it affects condition.

OTHER SIDE OF THIS DOCUMENT MUST BE FILLED OUT AND SIGNED TO BE CONSIDERED COMPLETE.

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Life Activities Limited due to the Diagnosis State Above				
Activity	N/A	Mild	Moderate	Severe
Breathing				
Interacting				
Self care				
Standing/Walking/Stairs				
Sitting				
Speaking				
Hearing				
Vision				
Chronic Pain				
Fatigued				
Agoraphobia				

Academic Activities Limited Due to the Diagnosis Stated Above				
Activity	N/A	Mild	Moderate	Severe
Focus				
Processing				
Reading				
Remembering				
Typing				

Medical or Mental Health Provider's Information:

Name _____ Title _____ License # _____

Signature _____ Telephone _____ Fax _____

Practice _____

** Hearing, vision, learning, or Autism Spectrum Disorder diagnoses require copies of testing results used to determine diagnosis to be attached to this form.*