LOS ANGELES PIERCE COLLEGE

AAC VERIFICATION OF DISABILITY FORM

Student Name: ____________________________ **Student ID#:** ____________________

In accordance with the Federal Family Educational Rights & Privacy Act (FFERPA) of 1974, or other laws, regulations, or policies, I hereby request verification of my disability on this form.
ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Date of Birth: _____________ **Student Signature:** ______________________________

THIS SECTION IS TO BE COMPLETED BY A LICENSED PROFESSIONAL

PRINT Professional's Name: ____

License #: ____

Professional's Address: ____

Professional's Phone #: ____

DSM-5-TR Diagnosis : ____

Educational Limitations Related to Diagnosis: _____________________________________

____

Duration of Disability: Check One Box ONLY

- ❑ PERMANENT / CHRONIC (No Scheduled Updates for Diagnosis)
- ❑ TEMPORARY (Lasting 45 days or longer) Indicate the time frame:___________________________

Professional's Signature: __________________________________ **Date:** _______________

PLEASE RETURN THIS FORM TO: LA PIERCE COLLEGE ACADEMIC ACCOMMODATIONS CENTER

EMAIL: AAC@PIERCECOLLEGE.EDU

ADDRESS: 6201 WINNTEKA AVE. WINNETKA, CA. 91371

PHONE: (818) 719-6430

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Date of Birth: _____________ **Student Signature:** _______________________________

THIS SECTION IS TO BE COMPLETED BY A LICENSED MEDICAL PROFESSIONAL

1. **Disability:** Please check all boxes that apply:
   - ❑ Aphasia
   - ❑ Amputee
   - ❑ Arthritis
   - ❑ Blind
   - ❑ Cardiac Disease
   - ❑ Cerebral Palsy
   - ❑ Deaf
   - ❑ Intellectual Disability
   - ❑ Diabetes
   - ❑ Epilepsy
   - ❑ Hard of Hearing
   - ❑ Hemiplegia
   - ❑ Hemophilia
   - ❑ Multiple Sclerosis
   - ❑ Neurological Damage
   - ❑ Other
   - ❑ Paraplegic
   - ❑ Post-Polio
   - ❑ Quadriplegic
   - ❑ Seizures
   - ❑ Thyroid Disease
   - ❑ Visually Impaired
2. **Duration of Disability:** Check One Box ONLY
   - ❑ PERMANENT / CHRONIC (No Scheduled Updates for Diagnosis)
   - ❑ TEMPORARY (Lasting 45 days or longer) Indicate the time frame:_________________________
3. **Basis of Disability Classification:** Check One Box ONLY
   - ❑ BY OBSERVATION
   - ❑ BY DOCUMENTATION
4. **Educational Limitations:** (Inability or Limited Ability)
   - ❑ Ambulate
   - ❑ Hear
   - ❑ Speak
   - ❑ See
   - ❑ Sit for Long Time
   - ❑ Use of Arms/Hands
   - ❑ Comprehend Reading
   - ❑ Understand Math
   - ❑ Compose an Essay
   - ❑ Retain Facts
   - ❑ Other ________________
5. **Source of Verification**

   PRINT Name of Licensed Professional: ________________________ **License #:** ____________

   Address: ____

   Phone #: ______________________________ Email: _________________________________

   Licensed Professional's Signature: _______________________________ Date: ___________