Academic Year:_____ ☐ Summer ☐ Fall ☐ Spring

WOODLAND COMMUNITY COLLEGE
Department of Supportive Programs and Services (DSPS)
2300 East Gibson Road, Building 700, Room 764, Woodland, CA 95776
Phone: (530) 661-5797 **Fax**: (530) 661-5788 **Email**: wccdsps@yccd.edu

Disability Verification and Consent Form

This section must be completed by the student:

Student's Last Name	First	Middle	
Street Address	City	State	ZIP
Telephone	DOB (MM/DD/YY)	Student ID#	

In order to receive disability-related services at Woodland Community College, a verification of disability must be provided. I request that the professional designated below complete this form for the purpose of verification.

Name of Licensed or Certified Professional	Telephone	Fax	
Street Address	City	State	ZIP

<u>Release of Information:</u> I consent to the release of specific written and verbal information regarding my disability to Woodland Community College, consistent with the Federal Family Educational Rights and Privacy Act (FERPA), or other laws, regulations, or policies for use in educational planning. All information will be kept confidential and maintained as part of my educational records with the DSPS department. I authorize the release of information to include the following records:

☐ Diagnosis of disability signed by the appropriate medical practitioner or psychologist
☐ Psychological testing and evaluation results
☐ Detailed results of assessments or testing that led to diagnosis
☐ Other _____

I further give permission for DSPS specialists to discuss these records with other professionals at WCC who have a legitimate educational need to know, and give permission for DSPS to forward records to other educational institutions per my request.

Student's Signature	Date	Parent/Guardian's Signature (if minor)	Date

This section must be completed by the licensed or certified professional:

Please provide the following information in full to help determine reasonable educational accommodations to support this student.

1. Diagnosis: _____ Date of onset: _____
2. DSM-V Code and Severity (if applicable): _____
3. Please describe how this condition limits or adversely impacts the student's education or major life activities:

_____

4. The condition is: ☐ Stable ☐ Prone to exacerbation
5. Duration of disability: ☐ Permanent/Chronic ☐ Temporary (Date expected to end:_____)

I understand that the information provided will become part of the student's educational record, and may be released to the student upon written request.

Verifying Professional's Signature	Date	Printed Name