Disabled Students Programs and Services

PLEASE SUBMIT COMPLETED FORM TO:
Disabled Students Programs and Services
Citrus College
1000 West Foothill Blvd., SS 133
Glendora, CA 91741-1899

DISABILITY DOCUMENTATION
PHYSICAL DISABILITY

The student named below may be eligible for academic accommodations provided through the office of Disabled Students Programs and Services (DSPS). In order to authorize these services, we must have written verification of the student's disability from his/her practitioner. Please be assured that the information provided by you will not appear in the student's academic record, will remain confidential in DSPS and will not be released to other persons unless instructed to do so by the student.

Please note: Student medical records supplied to this office constitute "educational records" under the Family Education and Privacy Act (FERPA) and as such, may be reviewed by the student upon written request.

PLEASE PROVIDE ALL INFORMATION REQUESTED

STUDENT: *Please complete this section only*

Name: ______________________ Citrus ID: ______________ Date of Birth: __________

Address: ______________________ City: ______________________ State: ________

ZIP: ______ Home Phone: ____________ Cell Phone: ____________ Email: ________________

Signature: ____ Date: __________

LICENSED PRACTITIONER:

Name: ______________________ Phone: ______________ Fax: ______________

Address: ______________________ City: ______________________ State: ________

Type of License: ______________ License No: __________ Area of Specialization: ______________

How often do you see the Student? ________________ Date of Student's Last Visit: ______________

Length of time this student has been under your care: ______________

Diagnosis 1: ____

Diagnosis 2: ____

Diagnosis 3: ____

This Diagnosis is considered: ☐ Permanent ☐ Progressive ☐ Temporary End Date: ______________

Please Complete Back Portion →

Medication-Related Effects on Academic Performance:

NAME OF DRUG WITH DOSAGE	PURPOSE OF MEDICATION	MEDICATION EFFECTS ON ACADEMIC PERFORMANCE Please check all that apply
1. ____________________	1. ____________________	☐ Confusion/Thought Disorder ☐ Distractibility
2. ____________________	2. ____________________	☐ Decreased Concentration ☐ Agitation
3. ____________________	3. ____________________	☐ Psychomotor Slowing ☐ Sedation/Fatigue
4. ____________________	4. ____________________	☐ Impaired Coordination Other: ____________

Disability-Related Effects on Academic Performance. Please check all that apply:

☐ Confusion/Thought Disorder ☐ Decreased Concentration ☐ Agitation ☐ Distractibility

☐ Impaired Coordination/Motor Function ☐ History of Impaired Performance on Timed tasks ☐ Chronic Pain

☐ Difficulty Sustaining Physical Energy Over Extended Periods of Time

☐ Please Elaborate:

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☐ Requires adaptive equipment to successfully perform routine tasks. Please Specify:

☐ Difficulty completing timed tasks due to:

☐ Please provide additional information that will help us understand how this student's disability affects their academic performance:

☐ Please provide us with your recommendations for academic accommodations for this student:

Signature of Licensed Provider: ________________________________ **Date:** ________________