SONOMA STATE UNIVERSITY
1801 East Cotati Avenue
Rohnert Park, CA 94928-3609

DISABILITY SERVICES FOR STUDENTS
Division of Student Affairs
707.664.2677 • Fax 707-664.3330 • Dial 711 for Relay
www.sonoma.edu/dss

MEDICAL VERIFICATION FORM

The student named below has applied for services from the Disability Services for Students (DSS) office at Sonoma State University. In order for DSS to establish whether this student has a disability and to determine eligibility for services we will need your assessment and diagnosis of this student. A disability is defined as a physical or mental impairment that limits one or more major life activity. You can fax or mail the form to us at the address listed on this form. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

For more information on DSS, please visit our website at www.sonoma.edu/dss

Student's name: _____

Student's address: _____ City, State, Zip: _____

Student's phone: _____ Date of birth: _____

1. What is the student's diagnosis/impairment?

2. When was the condition diagnosed?

3. Major Life Activities Assessment: Please use a checkmark to indicate the disability's impact, if any, on the activities listed below, and describe the impact if appropriate.

Life Activity	No impact	Moderate impact	Severe Impact	Don't know	Please describe if moderate or severe impact
Walking (e.g. how far/long can student walk**,** use of mobility devices such as wheelchair, etc.)	☐	☐	☐	☐	
Standing (e.g., duration)	☐	☐	☐	☐	
Sitting (e.g., duration)	☐	☐	☐	☐	
Performing manual tasks (e.g., reaching, manipulating materials & lab equipment, etc.)	☐	☐	☐	☐	
Writing/Keyboarding (e.g., unable to keyboard more than 10 min., unable to handwrite, etc.)	☐	☐	☐	☐	
Speech Impairment	☐	☐	☐	☐	
Breathing	☐	☐	☐	☐	
Sleeping (or attach most recent sleep study)	☐	☐	☐	☐	
Caring for oneself (e.g., personal care, laundry, household tasks, etc.)	☐	☐	☐	☐	
Hearing (or attach most recent audiogram)	☐	☐	☐	☐	
Vision (or attach most recent eye exam)	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

4. Please provide specific information about the academic limitations and severity of symptoms this student encounters as a result of his/her disability.

Limitation	No impact	Moderate impact	Severe Impact	Don't know	Please describe if moderate or severe impact
Concentration	☐	☐	☐	☐	
Organization	☐	☐	☐	☐	
Sustained focus	☐	☐	☐	☐	
Memory	☐	☐	☐	☐	
Understanding directions	☐	☐	☐	☐	
Managing internal distractions	☐	☐	☐	☐	
Managing external distractions	☐	☐	☐	☐	
Activation/initiating to work	☐	☐	☐	☐	
Timely submissions of assignments	☐	☐	☐	☐	
Stress management	☐	☐	☐	☐	
Other	☐	☐	☐	☐	

5. Please describe the effect the medical condition has on academic performance (e.g., concentration, reading, thinking, learning, etc.) and attendance.

6. If the student is prescribed medication related to this condition, please indicate the possible side-effects on academic performance and/or attendance.

7. If student is currently undergoing treatment, please describe how treatment (e.g., frequency of treatments, side-effects of treatments, etc.) may affect the student's academic performance and/or attendance.

8. Is this condition permanent or temporary?

- ◯ Permanent
- ◯ Temporary

9. If the condition is temporary, when will the functional limitations associated with the condition be resolved?

10. Please attach any relevant supporting documentation (e.g., sleep studies, eye exams, audiograms, etc.).

Certifying Medical Professional

Printed Name: _____

Signature of Medical Professional: _____ Date: _____

License Number: _____

Address: _____ City, State, ZIP: _____

Telephone Number: _____ Fax: _____