



DISABILITY VERIFICATION

Date:

The student named below may be eligible for special classes/services at Coastline Community College. In order to provide services, **we must have a verification of disability.**

NAME:

DOB:

SS:

ADDRESS:

Please provide the following information in full:

1. Description of Disability: (1.1) *acquired brain injury secondary to*

(1.2) Secondary Disability (if applicable)

2. Functional Limitations:

3. Prescribed Medications and Dosage:

4. The above-mentioned disability (ies) is/are:

Permanent/Chronic

Temporary

Less than 45 days

45 days or greater

5. Do you recommend other special assistance?

6. This disability is: Not observable

Observable

It is understood that information furnished on this form is provided with a written release from the above-named student and will be used in confidence for the educational benefit of this student.

Signature of Certifying Professional

Date