

Pasadena City College
DISABLED STUDENT PROGRAMS & SERVICES
1570 E. Colorado Blvd. Pasadena, CA 91106-2003
(626) 585-7127 FAX (626) 585-7566
DISABILITY DOCUMENTATION

Dear Student,

To receive services through Pasadena City College DSPS, we must document your disability. This form may help you document your disability. This form may be completed by a Physician, Licensed Clinical Psychologist, Psychiatrist, MFT, LCSW, MD or other licensed, credentialed or certified professional. If current disability documentation is not available, but your disability is chronic and stable, please have one of the professionals mentioned above, provide information from historical records.

NAME: _____ DATE _____
ADDRESS: _____ STATE: _____ ZIP: _____
PHONE: (Home) _____ (Cell) _____
DOB (Date of Birth) _____ STUDENT ID: _____

Dear Professional: Please fill in the remainder of this form.

Check all disabilities that apply:

<input type="checkbox"/> Psychological Disability	<input type="checkbox"/> Acquired Brain Impairment	<input type="checkbox"/> Learning Disability
<input type="checkbox"/> Speech or Language Impairment	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Mobility Impairment
<input type="checkbox"/> Developmental Delayed Learner	<input type="checkbox"/> Visual Impairment	<input type="checkbox"/> Other Disability _____

Diagnosis #1: _____

This condition is: Permanent/chronic Recurring Temporary -duration: _____

Level of Severity: Mild Moderate Severe Date of Diagnosis: _____

Diagnosis #2: _____

This condition is: Permanent/chronic Recurring Temporary -duration: _____

Level of Severity: Mild Moderate Severe Date of Diagnosis: _____

This/these condition(s) and/or the medication prescribed result(s) in the following functional limitations:

<input type="checkbox"/> Difficulty seeing, hearing or speaking	<input type="checkbox"/> Memory problems
<input type="checkbox"/> Difficulty concentrating/focusing on tasks	<input type="checkbox"/> Difficulty communicating needs
<input type="checkbox"/> Panic in unfamiliar surroundings/situations	<input type="checkbox"/> Poor stamina/endurance
<input type="checkbox"/> Difficulty formulating and executing plan of action	<input type="checkbox"/> Trouble breathing
<input type="checkbox"/> Trouble learning/performing cognitive tasks	
<input type="checkbox"/> Physical issues related to walking, standing, sitting, writing/performing manual tasks, and/or stair-climbing	
<input type="checkbox"/> Other _____	

SIGNATURE: _____

Licensed Professional

PRINT NAME: _____

PRINT TITLE: _____ LICENSE#: _____

ADDRESS: _____

PHONE: _____ DATE: _____