California Baptist University

Disability Services
Medical Disability Verification

1. Student Name: _____ ID#: _____

2. Diagnosis or Condition:
_____
_____
_____

3. Date of Initial Diagnosis: _____

4. What is the expected duration of the condition?

   ☐Permanent

   ☐Chronic

   ☐Temporary

   How long will the student need accommodations? _____

   Please explain: _____

   _____

   _____

5. Does the student experience functional limitations that will substantially impact academic success? Please explain:
_____
_____
_____

6. Medical Doctor's Name: _____

   Telephone Number: (_____) _____ License Number: _____

   Medical Professional Signature: _____ Please Print to Sign _____ ***Date:*** _____

Please send the completed form to the selected Disability Services Administrator:

☐ **Pamela Jost, M.S.**
Director of Disability Services
The Office of Student Success
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(951)343-4962

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