



Disability Verification

2500 E. Nutwood Ave.
Fullerton, CA 92831 USA
(714) 879-3901
Email: kmclark@hiu.edu

Date: _____

The student named below may be eligible for special services at this college. In order to provide services, we must have a verification of disability.

Name: Last _____ First _____ M.I. _____ HIU ID# _____

Address _____ City _____ Zip Code _____

Please provide the following information in full:

1. Description of Primary Diagnosis: _____

2. Functional Limitations (i.e., limited ambulation, visual acuity, degree of hearing loss, etc.): _____

3. How Limitations Impact Learning: _____

4. The above-mentioned disability(ies) is/are:
☐ Permanent / Chronic
Short-term Temporary: ☐ Less than 45 days ☐ 45 days or greater
5. Please list special assistance needed: _____

If this form is completed by someone other than the professional who made the diagnosis, the name and address of the person who made the diagnosis should also be listed below:

Signature _____
(Certifying Professional) _____ Title _____

Name (printed) _____

Address _____

Phone _____

Please return to: **Dr. Karen Clark**, Student Success Coordinator
Email: kmclark@hiu.edu Phone **714.879.3901** ext. **1263**
Hope International University, 2500 E. Nutwood Ave., Fullerton, CA 92831