San Diego Global Knowledge University
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Competency with Global Knowledge

DISABILITY VERIFICATION

Submission Instructions

Once you have completed this form, please print, sign, or e-sign, and submit to the Director of Admissions and Registrar. Tel (619)934-0797 | dparker@sdgku.edu
Note: Accepted formats: .PDF or Word (.DOC or .DOCX). Submitting a form in any other format may require resubmission or result in a delay in processing.

San Diego Global Knowledge University (SDGKU) prohibits discrimination on the basis of a disability in accordance with section 504 of the Rehabilitation Act on 1973, and the Americans with Disabilities Act (ADA) in 1990, as amended. SDGKU is committed to providing an equal opportunity to access a full educational experience and reasonable accommodations will be granted to students who document a disability and are otherwise qualified to participate in the specific academic program or activity.

Student Information

First Name: _____ Last Name: _____

Please provide the following information in full to help determine reasonable accommodations to support the student:

Diagnosis and Limitations (Documentation of Disability)

Primary Diagnosis: _____ Dx Code: _____

Secondary Diagnosis: _____ Dx Code: _____

Limitations related to above diagnosis/diagnoses as they pertain to the educational setting.

_____

Impact upon (check all that apply:

☐ Concentration ☐ Emotional ☐ Memory ☐ Mobility ☐ Vision ☐ Wellbeing

☐ Other: _____

Condition is: ☐ Stable ☐ Prone to Exacerbations

Duration of Disability: ☐ Permanent ☐ Temporary Anticipated Duration From: _____ to _____

Accommodation Recommendations

Description of any medications, assistive devices, auxiliary aids, services, or accommodations currently in use or used in the past that may assist in the provision of educational accommodation(s):

Additional recommendations for accommodation(s) that may assist in accessing the educational environment:

Specific documentation of exacerbation of symptoms for special consideration

Dates impacted by exacerbation of symptoms/hospitalization: From: To:

Description of the exacerbated symptoms and how they impacted participation in the educational environment (This may include, but is not limited to office visits, surgery, hospitalizations or medication changes):

Professional Certification

Signature of Certifying Professional: Title:

License number: Address:

First Name: Last Name:

Phone: Date: Stamp: