UNIVERSITY OF CALIFORNIA, SAN DIEGO UCSD

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UC SAN DIEGO DIVISION OF EXTENDED STUDIES
STUDENT SERVICES
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LA JOLLA, CALIFORNIA 92093-0176
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Documentation Form for Medical Conditions

The student below has requested accommodations on the basis of a Medical Condition through the Student Services at UC San Diego Division of Extended Studies.

In order to verify the disability, its severity, its impact on one or more major life activities, and to determine reasonable accommodations, your diagnosis and assessment of this student is needed. Documentation must be current (i.e. most recent visit should be within the last 3 months). Please attach any supporting documentation (audiology reports, optometry exams). All information will be kept confidential.

Student Name_____DOB _____

Student ID Number _____

Student Authorization:

I, _____, am requesting academic support services through UC San Diego Division of Extended Studies Student Services. They require current and comprehensive documentation of my disability/medical condition prior to receiving services through UC San Diego Division of Extended Studies. I acknowledge that by requesting academic accommodations, I am authorizing the UC San Diego Division of Extended Studies Student Services Disability Coordinator to discuss information relevant to my disability with my medical provider. I understand UC San Diego Division of Extended Studies will keep my information confidential as per UC Policy and Procedures Manual Section 160-2.

Student Signature: _____ **Date:** _____

TO BE COMPLETED BY CERTIFYING PROFESSIONAL

Name/Title of Certifying Professional (Please Print)_____

License #_____State _____

Address _____

Telephone Number_____Fax Number _____

Provider Certification:
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above. In cases where the diagnostic assessment of the student was performed by another clinician, my signature confirms the review of the original assessment and agreement of the diagnosis.

OR

If you feel you **CANNOT** provide documentation for this student, please indicate the reason below:

____ I am not treating this student

____ I have referred to another clinician

____ I would need additional sessions with the student to complete this form

____ Other _____

____ I have not diagnosed this student

____ I have referred for additional evaluation

____ I have insufficient information to describe functional limitations that would impact the student's academic work/major life activities

Provider Signature: _____ **Date:** _____

1. What is the **diagnosis(es)/ impairment(s)** that you are **CURRENTLY** treating?

   _____

   _____

2. What is the initial date of the diagnosis and describe the assessments/procedures used in determining the diagnosis. If unknown, is this the student's self-report?

   _____

   _____

3. When was your most recent appointment with the student for this diagnosis? _____

4. Is the condition (circle one): TEMPORARY? PERMANENT?

5. Is the condition (circle one): STABLE? PROGRESSIVE?

6. Activities Assessment: Please check which of the activities are affected because of the diagnosis/impairment and indicate the level of limitation with ***current treatment protocols***. Please assess all activities and indicate if you observed them and/or if they are self-reported by the student. If not applicable, please check the box marked 'No Impact.'

	Level of Limitation				**Observation**	
Activity	**Mild Impact**	**Moderate Impact**	**Severe Impact**	**Unknown**	**Self-Reported**	**Medical Professional**
Talking						
Hearing						
Breathing						
Standing						
Working						
Reaching						
Lifting						
Sitting						
Walking						
Seeing						
Writing						
Performing Manual Tasks						
Sleeping						
Learning						
Reading						
Thinking						
Concentrating						
Memorizing						
Interacting with Others						
Self-Care						
Other						

7. Describe the student's **specific and current functional limitations** that result from the impairment's impact on the activities listed in Question 6, particularly with regard to an academic environment. If the level of limitation is **severe**, please discuss in greater detail. If they have a condition that flares, how often and for what duration do these flares occur?

_____
_____
_____
_____
_____
_____

8. Indicate the dates that the student has been or will be incapacitated.

_____
_____

9. Describe any medications and/or treatments currently being used by the student including type, dosing, effectiveness, and side effects. How recently has the medication been changed?

_____
_____

10. Is the student compliant with his/her treatment plan? YES NO
11. Is the student compliant with medication/therapeutic protocols? YES NO
12. Is the student compliant with recommended referrals? YES NO

13. Explain how the medication modifies the impact that the disability has on the student's condition.

_____
_____
_____
_____

14. Although accommodations will be determined by the UC San Diego Division of Extended Studies Disability Coordinator based upon the current functional limitations you have outlined, in your professional opinion, are there any accommodations you would recommend; i.e., ADA transport, shower chair, note-taking, scribes?

_____
_____
_____
_____
_____

15. Please attach any other supporting documentation including; i.e., vision, audiology, cognitive, psychological.