UNIVERSITY OF CALIFORNIA SAN DIEGO

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SANTA BARBARA • SANTA CRUZ

OFFICE FOR STUDENTS WITH DISABILITIES
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9500 GILMAN DRIVE DEPT 0019
LA JOLLA CALIFORNIA 92093-0019
WEB: http://osd.ucsd.edu

Documentation Form for Medical Conditions

The student below has requested accommodations on the basis of a Medical Condition through the Office for Students with Disabilities (OSD) at UC San Diego. 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. In accordance with professional ethics, this form may not be completed by a family member.

Student Name ______________________________ DOB ____________________

Spouse/Dependent's Name ______________________________ DOB ____________________

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 not diagnosed this student

____ I have referred to another clinician

____ I have referred for additional evaluation

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

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

____ Other ______________________________

Signature ______________________________

Date ______________________________

For OSD staff use only:

Student Name ____ DOB__________________________

Spouse/Dependent's Name____ DOB__________________________

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. List the dates you saw the student within the last 6 months for this diagnosis(es)?

   ____

   ____

5. Is the condition TEMPORARY? PERMANENT? (circle one)

6. Is the condition STABLE? PROGRESSIVE? (circle one)

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

   ____

   ____

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

   ____

   ____

   ____

9. What are the specific side effects that the student has reported, if any? Explain how the side effects of the medication impact the student's disability.

   ____

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   ____

   ____

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

For OSD staff use only:

Student Name ____ DOB___________________________

Spouse/Dependent's Name ____________________________________ DOB___________________________

13. 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. If not applicable, please check the box marked 'No Impact.'

Activity	No Impact	Mild Impact	Moderate Impact	Severe Impact	Don't Know	**Self-Report**	**Observed by 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							

Please indicate whether you have observed this or if it is self-reported.

14. Describe, **in DETAIL,** the student's **current and specific functional limitations related to disability** (i.e., how the student specifically is impacted by disability, how disability impacts the student on a daily basis, what other activities is student unable to do or other areas that are significantly impacted due to disability, etc.). If they have a condition that flares, how often and for what duration do these flares occur?

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____

____

For OSD staff use only:

Student Name ____ DOB__________________________

Spouse/Dependent's Name ___________________________________ DOB__________________________

15. Is the student requesting any Housing accommodations:
Please circle: **YES** **NO**

If YES, please describe **IN DETAIL** how housing accommodations would mitigate the current and specific functional limitations related to the student's disability:

____

____

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____

____

16. Although accommodations will be determined by the OSD Disability Specialist 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? Please provide information regarding WHY you are recommending these accommodations:

____

____

____

____

____

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

For OSD staff use only: