UNIVERSITY OF CALIFORNIA SAN DIEGO

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SAN FRANCISCO SANTA BARBARA • SANTA CRUZ

OFFICE FOR STUDENTS WITH DISABILITIES
TEL: (858) 534-4382
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LA JOLLA, CALIFORNIA 92093-0019
https://osd.ucsd.edu

Documentation Form for Remote Instruction, Participation, and Assessment as an Accommodation

The student below believes that their disability precludes them from in-person instruction, participation, and assessment in one or more courses due to their disabling condition. In order to verify the disability, its severity, its impact on one or more major life activities, and to determine reasonable accommodations, your 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.

- An accommodation for remote instruction is designed to be temporary. OSD will only consider the functional limitations that impact a student in the classroom and are an institutional responsibility to mitigate. We do not consider: housing, social support, medical appointments, treatments, transportation to campus, financial constraints, or convenience.

- An accommodation for remote instruction will not be considered reasonable under the law if, in communication with instructors, it is determined that this constitutes a fundamental alteration of the course.

- Remote accommodations typically provide **synchronous** access to a live stream of lectures and sections. Accommodations that would allow for in person attendance to mitigate institutional barriers must be considered before remote instruction, participation, and assessment is approved.

- When an accommodation for remote instruction is approved, students may be required to take exams, quizzes, and other assessments on campus and in person, unless a separate accommodation is requested and approved.

- Students are expected to meet the participation and attendance requirements outlined in the syllabus and have their cameras on during class and exams, unless a separate accommodation is requested and approved.

- Please complete this form and return it to the OSD via email (osd@ucsd.edu) or via fax (858-534-4650).

For OSD staff use only:

Student Name_____ DOB _____

Name/Title of Certifying Professional (Please Print) _____

License # _____State _____

Address _____

Telephone Number _____ Fax Number _____

Email (for follow up questions) _____

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

Signature_____

Date_____

For OSD staff use only:

Student Name _____ DOB_____

If you have completed the student's recent Documentation Form for the OSD for the disability you are referencing for requesting remote instruction, **you may skip to Question #15**.

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.

   _____

   _____

   _____

   _____

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_____

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

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							

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?

_____

_____

_____

_____

_____

_____

For OSD staff use only:

Student Name _____ DOB_____

15. Please explain how the student's disability creates a significant barrier to their full and meaningful participation in an on-campus living and learning experience.

_____

_____

_____

16. Describe any disability related specific impacts (functional limitations) that the student is likely to experience in the physical classroom.

_____

_____

_____

17. Please explain how the student's disability creates a significant barrier to their in-class attendance.

_____

_____

_____

18. Based on the overall severity of the condition, have you and the student discussed a reduced course load (less than 12 units). YES ☐ NO ☐

19. Please explain why a reduced course load would not mitigate the specific functional limitations described above.

_____

_____

_____

20. Based on the overall severity of the condition, have you and the student discussed modified attendance (increased flexibility for in-person classes not to exceed 20% of the 10 week quarter?

_____

_____

_____

21. Please explain why modified attendance would not mitigate the specific and current functional limitations described above.

_____

_____

_____

For OSD staff use only:

22. Have you and the student discussed a leave of absence? YES ☐ NO ☐
23. Please explain why a leave of absence would not mitigate the specific and current functional limitations described above.

_____

_____

_____

24. Does the diagnosis require the student to remain quarantined or socially isolated? YES ☐ NO ☐
25. If quarantine or social isolation is required, are there measures that can be put in place to mitigate concerns when the student must be in the presence of others; i.e., masking, social distancing? Please specify the nature and effectiveness of these measures.

_____

_____

_____

26. Please provide any additional information that should be considered when evaluating the student's request.

_____

_____

_____

For OSD staff use only: