OFFICE FOR STUDENTS WITH DISABILITIES
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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.

Student 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 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 ___________________________________

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

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

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.'

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							

Student Name ____ DOB __________________________

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.

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14. 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?

____
____
____
____
____

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