UNIVERSITY OF CALIFORNIA
SANTA CRUZ

Disability Resource Center
1156 High Street, 125 Hahn Student Service
PHONE (831) 459-2089
FAX (831) 459-5064

Documentation of Medical or Psychological Condition

This form is intended for licensed health care providers to complete to support the provision of academic accommodations for eligible students at UC Santa Cruz. Under the Americans with Disabilities Act or the Rehabilitation Act, disability is defined as **any physical or mental impairment** that **substantially limits one or more major life activities** such as: *caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, or working*.

Please return to the Disability Resource Center at UC Santa Cruz in a timely manner so that we can support the implementation of accommodations and equal educational access. Thank you for your time in filling out this form.

Section I: To be completed by student

Student Name: _____ Student ID #:_____

Birthdate (MM/DD/YY): _____ Date: _____

Section 2: To be completed by professional

Name of Physician/Professional: _____

Title/Specialty: _____ License or Certification #: _____

Professional Address: _____

Phone Number: _____ Fax: _____

Please respond completely to the following questions:

1. How long have you been working with this individual? _____
2. When did you last see this individual?_____
3. Describe the student's condition, symptoms, or diagnosis, and the impact on academics/housing/dining:

4. When did this condition develop or when was it diagnosed? What is the current prognosis and length of condition?

5. What were the assessment or evaluation procedures used?

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6. Please check level of impact in the following major life activities listed below:

Life Activity	No Impact	Moderate Impact	Severe Impact	Don't Know
Concentrating				
Memory				
Learning				
Talking				
Reading				
Writing				
Seeing				
Listening				
Standing				
Walking				
Sleeping				
Eating				
Social Interactions				
Self-Care				
Managing Internal Distractions				
Managing External Distractions				
Timely Submission of Assignments				
Attending Class Regularly and On Time				
Stress Management				
Organization				

7. What, if any, medication is the student currently taking? Are there any substantial side effects for this individual?

8. Do you have any recommended accommodations related to disability, including those used in the past?

I verify that the information provided is complete and accurate to the best of my knowledge and certify that I am not related to the student.

Signature of Physician or Professional: _____ Date: _____