

## DISABILITY VERIFICATION FORM

### SECTION I: To be completed by student

Student Name (Please PRINT clearly) \_\_\_\_\_ Birthdate \_\_\_\_\_

I am requesting academic support services through the Disability Services Center at UCI. They require current and comprehensive documentation of my disability and functional limitations. Please respond to the following questions as soon as possible and return to me or send by mail or fax. I authorize the Disability Services Center at UCI to contact you if clarification is needed.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_ UCI ID # \_\_\_\_\_

### SECTION II: To be completed by professional only

Please provide the following information in order to help us determine reasonable educational and physical accommodations:

1. Diagnosis: \_\_\_\_\_

If applicable: DSM V Code: \_\_\_\_\_ Severity:  Moderate  Severe  Remission

2. This condition substantially limits the following major life activities: (Required)

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Class Attendance                        | <input type="checkbox"/> Caring for Self        | <input type="checkbox"/> Communicating        | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Hearing (attach audiogram)              | <input type="checkbox"/> Interpersonal Skills   | <input type="checkbox"/> Social Interactions  | <input type="checkbox"/> Sitting       |
| <input type="checkbox"/> Meeting Deadlines                       | <input type="checkbox"/> Managing Distractions  | <input type="checkbox"/> Managing Stress      | <input type="checkbox"/> Stamina       |
| <input type="checkbox"/> Memorizing                              | <input type="checkbox"/> Organization           | <input type="checkbox"/> Perform Manual Tasks | <input type="checkbox"/> Reading       |
| <input type="checkbox"/> Sleeping                                | <input type="checkbox"/> Processing Information | <input type="checkbox"/> Taking Class Notes   | <input type="checkbox"/> Writing       |
| <input type="checkbox"/> Visual Impairment (attach prescription) | <input type="checkbox"/> Blind                  |   |  |

3. List other limitations/information helpful in determining accommodations in an educational setting:

\_\_\_\_\_

\_\_\_\_\_

4. Medication Side Effects: \_\_\_\_\_

5. Duration:  Permanent (lasting longer than 6 months)  Temporary – End Date: \_\_\_\_\_

6. Date of Diagnosis: \_\_\_\_\_ Date of last contact: \_\_\_\_\_

I understand that the information provided in this form will become part of the student record subject to the Federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Name of Physician or Certified/Licensed Professional: \_\_\_\_\_

Title/Specialty: \_\_\_\_\_ License or Certification #: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

Signature of Physician or Certified/Licensed Professional: \_\_\_\_\_ Date: \_\_\_\_\_