UC SANTA BARBARA
Disabled Students Program
2120 Student Resource Building, University of California
Santa Barbara CA 93106-3070
http://dsp.sa.ucsb.edu

UCSB Disabled Students Program
Remote Participation Provider Form

To be completed by the student's current treating Provider

- *The ADA serves to provide equal access to educational opportunities. The opportunity available to all students is in person, synchronous attendance. Accommodations that would allow for in person attendance to mitigate institutional barriers must be considered before remote participation can be approved. Provider recommendations do not create accommodation mandates.*

- *This accommodation is designed to be temporary and not a substitute for treatment. The scope of consideration for this accommodation is narrow. DSP may only consider the* ***functional limitations*** *(noted by the provider) that impact the student* ***in the classroom*** *and are an institutional responsibility to mitigate. DSP* ***may not consider****: Housing, social support, medical appointments, treatment issues, transportation on or to campus, comfortability, time to degree, preferences, risks, or condition related symptoms or pain, etc.*

- *This accommodation provides access to a live stream of lecture/section. Students may be required to take exams/quizzes on campus and in person.*

- *Thank you in advance for your time and consideration in completing this form. Your input is greatly appreciated.*

SECTION I: DIAGNOSIS

Instructions: Completely answer the following questions as the student's current treating provider

Today's date: _____ Student's name: _____

Student date of birth: _____

How long have you been treating this student? _____

Date of your last evaluation of student: _____

What is the student's diagnosis/diagnoses (Please include appropriate codes)?
_____

Please list the tests or measures used to assess the student

_____

How does this accommodation fit with your treatment plan?

_____

Date of your initial diagnosis: _____

How many times have you seen this patient? _____

What is the anticipated duration of the **condition**:_____

The overall severity of the condition (check only one):

☐ Mild
☐ Moderate
☐ Substantial
☐ Severe

Based on your treatment plan, please estimate the expected duration **of severity** noted above:

_____

SECTION II: FUNCTIONAL LIMITATIONS

Functional limitations refer to the impacts that result from symptoms. These limitations may create barriers in the classroom. UCSB will accommodate functional limitations that intersect with institutional barriers as opposed to symptoms and treatment issues.

What are the student's current **functional limitations** due to their condition(s) that preclude physical in-person attendance? Check all that apply:

- ☐ Ambulation
- ☐ Motor Function
- ☐ Hearing
- ☐ Vision
- ☐ Cognitive Processing
- ☐ Social
- ☐ Emotional
- ☐ Other: _____

Describe any physical functional limitations that the student is likely to experience in class.

Describe **how** accessible furniture (sit-stand desk, ergonomic chair, etc.) & positioning will **not** mitigate these limitations.

Describe any cognitive/psychological functional limitations the student is likely to experience in class:

The following questions pertain to reasonable course design accommodations:

Based on the overall severity of the condition, have you and the student discussed a reduced course load? Please explain why you do not believe a reduced course load is indicated

Based on the overall severity of the condition, have you and the student discussed modified attendance (increased absence flexibility for in-person classes, not to exceed 20% of the 10 week quarter)? Please describe why modified attendance would not be appropriate:

Based on the overall severity of the condition, have you and the student discussed modified participation (modifications to the course participation requirements)?

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

Please describe how the student can manage the severity of the condition and the full demands of an academic course load:

Does the diagnosis require the student to remain quarantined or socially isolated?

- ☐ Yes
- ☐ No

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 (masking, social distancing)? Please specify the nature and effectiveness of these measures:

Can measures be put in place to mitigate disability-related functional limitations for in-person exams? Please specify the nature and effectiveness of these measures:

Please note any additional comments or concerns that would be helpful to know in evaluating the student's request for the Remote Participation Accommodation:

SECTION III: PROVIDER INFORMATION

Name of medical/mental health professional*: _____

Title and license number*: _____

Address of medical/mental health professional: _____

Phone number: _____

Fax Number: _____

Email* (for follow-up questions): _____

Signature*: _____ Date: _____

Signature of Supervisor (if applicable for interns and professionals in training): _____ Date: _____

Title and license number*: _____

***required field**