UC SANTA BARBARA
Disabled Students Program

Disability Verification Form: Permanent Medical Condition

Today's Date:_____
Student's Name:_____
Student's 7-Digit ID #:_____
Student's Phone Number:_____
Student's Email:_____

DSP is responsible for providing academic support services (accommodations) for students who qualify as an individual with a disability. DSP requires comprehensive documentation in order to determine if the condition rises to the level of disability under the Americans with Disabilities Act as Amended (ADAAA) of 2008 and Section 504 of the Rehabilitation Act of 1973. If so, the student may be entitled to reasonable accommodations.

Date of your initial diagnosis: _____
How long have you been treating this student? _____
How many times have you seen this patient? _____
Is the student currently in treatment with you?_____
Date of your last evaluation of student: _____
What is the anticipated duration of the condition:_____

1. What is the specific diagnosis related to the condition (list all applicable ICD-10 codes):

2. What are the current functional limitations imposed by this condition?

What is the overall level of their severity?

◯ Mild ◯ Moderate ◯ Severe ◯ Partial Remission ◯ Residual Status

Please list functional limitations impacting experience in the classroom and click the circle that indicated their level of significance:

1: _____ ◯ Mild ◯ Moderate ◯ Severe

2: _____ ◯ Mild ◯ Moderate ◯ Severe

3: _____ ◯ Mild ◯ Moderate ◯ Severe

4: _____ ◯ Mild ◯ Moderate ◯ Severe

5: _____ ◯ Mild ◯ Moderate ◯ Severe

3. What specific assessments or evaluation procedures were used to make the diagnosis? Please explain.

4. If appropriate, please provide any historical data used in determining the diagnosis, including any additional diagnoses the student may have.

5. Provide a list of medication(s), dosage, side effects, and time frame the student has been on current medicine regimen.

6. Provide an individual assessment of side effects of medication, if any.

7. If this diagnosis involves periodic flare-ups in symptoms that <u>increase severity of functional limitations</u>, please indicate the level of severity of the frequency and duration of flare-ups.

   Frequency of Flare-ups: ◯ Daily ◯ Weekly ◯ Monthly+

   Duration of Flare-ups: ◯ Hours ◯ Days ◯ Weeks

8. Is there anything additional you would like to share about the student that may help DSP in the accommodation determination process?

Provider Name: _____
License/Certification #: _____
Signature: _____ Date: _____
Phone: _____ Fax: _____

How to Submit Documentation to DSP

You may return the completed form in any of the following ways:

- **Fax**: (805) 893-7127
- **Mail**:
  University of California, Disabled Students Program
  2120 Student Resource Building
  Santa Barbara, CA 93106-3070
- **Via Student**: Give the form to the student, who can upload it to the portal.

Important: Documentation is incomplete without the clinician's signature.

For questions, please call DSP at (805) 893-2668. Thank you for your assistance!