UCLA Center for Accessible Education

A255 Murphy Hall
Box 951426
Los Angeles, CA 90095-1426

VERIFICATION OF DISABILITY FORM
MEDICAL, MOBILITY, & SENSORY DISABILITIES

Student Name: _____ Date of birth: _____

Purpose: The student named below has indicated that he or she has a disability and will require reasonable accommodations to participate in a program or activity at UCLA. The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested accommodations or services. **Please take the time to complete this form in its entirety.** Contact the Center for Accessible Education at (310) 825-1501 with any questions. All information provided to us is kept confidential in accordance with the Family Educational Rights and Privacy Act (FERPA). A signed consent for release of information should be completed by the student prior to the release of this form. Thank you for your assistance.

Note to student: Please do not complete this form -- **it must be completed by your treating clinician.**

Name of Health Care Provider: _____

License #: _____ State of Licensure: _____

Address: _____

Telephone: _____

Signature (verifying that you are not related to the student by blood or marriage):

_____

Dates of treatment with current provider/facility:

_____

_____

Date student was last seen: _____

Medical Diagnosis(es): _____

_____

Onset of Condition(s): _____

Current Status of Condition(s) (i.e. Active, Progressing, Controlled, In Remission):

How long is this condition(s) likely to persist?

☐Permanent *(Lifetime)*

☐Chronic/recurring *(Likely to last for duration of college attendance)*

☐Temporary *(One quarter, one month, etc.)*

Date disability will end:_____ *(Accommodations not necessary after this date.)*

Please list procedures/assessments used to diagnose this student's condition:

_____

What are the student's **current functional limitations** (*be as specific and detailed as possible and provide information for all disability areas*): 1) ambulation; 2) upper extremity motor function; 3) hearing; 4) vision; 5) cognitive processes—concentration, rapidity of information processing, fatigability, others:

_____

_____

_____

_____

_____

_____

In comparison to someone in the general population, please rate the severity of the student's functional limitations noted above, both with and without the use of mitigating measures (interventions), such as medication and treatment:

Without Mitigation (Intervention):
Mild ☐
Moderate ☐
Substantial ☐
Severe ☐

With Mitigation (Intervention):
Mild ☐
Moderate ☐
Substantial ☐
Severe ☐

What exacerbates the specific disability(ies) this student has? (*again, be as specific and detailed as possible*): _____

_____

_____

If the student currently takes medications related to the condition(s), please describe any functional limitations as a result of the medication:

_____

_____

_____

_____

Please describe the impact that the student's condition will have on his/her/their ability to attend or participate in classes:

_____

_____

_____

Please describe the impact this student's condition has on his/her/their overall ability to learn, or on other cognitive abilities:

_____

_____

_____

_____

If the student's condition is asthma, please comment on the frequency and duration of asthmatic attacks.

_____