UCI IRVINE | DISABILITY SERVICES CENTER STUDENT AFFAIRS

100 Disability Services, Irvine, CA, 92697-5250
949.824.7494 949.824.3083 *fax*

Verification of Medical/Physical/Perceptual Impairment

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/medical condition. 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 # _____

Physician/Provider Name (print)**:** _____ **Title:** _____

Phone: _____ **Fax:** _____

Organization & Address: _____

1. The Health Care Professional listed above must complete this form in its entirety.
2. Please describe the resulting limitations, symptoms, and/or side effects of medications experienced by the student in the educational environment.

Diagnosis	Prognosis	Limitations/Symptoms/Side Effects

Additional Questions

_____ **Date of Diagnosis**

_____ **Date of Initial Meeting**

_____ **Date of Last Professional Contact**

1. Is the individual currently in treatment with you? (Please circle one) Yes No

2. Severity and Duration

LEVEL OF SEVERITY	☐ Mild ☐ Moderate ☐ Severe	**DURATION**	☐ Permanent ☐ Chronic/Recurring (likely to last for duration of college attendance) ☐ Temporary - Date disability will end: _____

3. Is there anything else you would like us to know about the student? *(Optional)*

This information is correct and accurate to the best of my knowledge on my recent evaluation of this patient and/or my review of records.

Physician Signature: _____ **License #:** _____ **Date:** _____

All information on this form will remain confidential.