UCI Disability Services Center

Continuing Education 3, Bldg #234
Pereira Drive, Irvine, CA 92697-5250
Tel 949.824.7494
Fax 949.824.3410

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)

❑ Class Attendance	❑ Caring for Self	❑ Communicating	❑ Concentrating
❑ Hearing (attach audiogram)	❑ Interpersonal Skills	❑ Social Interactions	❑ Sitting
❑ Meeting Deadlines	❑ Managing Distractions	❑ Managing Stress	❑ Stamina
❑ Memorizing	❑ Organization	❑ Perform Manual Tasks	❑ Reading
❑ Sleeping	❑ Processing Information	❑ Taking Class Notes	❑ Writing
❑ Visual Impairment (attach prescription)		❑ 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:**__________

lkp 06/2017