

**UC Irvine – Disability Services Center**

100 Disability Services Irvine, CA 92697-5130

(949) 824-7494 (949) 824-3083 (fax)

*Verification of Disability*

Student name _____ Birthdate _____
<i>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.</i>
Student Signature _____ Date _____

Physician/provider name (print): \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Organization & address: \_\_\_\_\_

**This form must be completed by the Health Care Professional listed above.**

**Diagnosis (es)** \_\_\_\_\_ **Diagnosis date** \_\_\_\_\_

**Level of severity:**       Mild                       Moderate                       Severe

**Duration:**  Permanent                       Chronic/recurring (*Likely to last for duration of college attendance.*)

Temporary    **Date disability will end:** \_\_\_\_\_ (*Accommodations not necessary after this date.*)

**Please list procedures/assessments used to diagnose this student’s condition.**

**What treatment and/or medications are currently being used?**

**What are the functional limitations or symptoms?**

**How does this condition (or effects of medication) limit this student’s ability to learn or to meet the demands in a University setting?**

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

Physician Signature \_\_\_\_\_ License # \_\_\_\_\_ Date \_\_\_\_\_