UC RIVERSIDE | Student Disability Resource Center

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sdrc.ucr.edu

CERTIFICATION OF CHRONIC PHYSICAL DISABILITY

The student named below has applied for services from the Student Disability Resource Center (SDRC) at UC Riverside. In order to determine eligibility and to provide services, we require documentation of the student's Disability. Under the Americans with Disabilities Act as Amended (ADAAA) of 2008 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a specific disability exists and that the identified disability substantially limits one or more major life activities. A diagnosis of a disorder in and of itself does not automatically qualify an individual for accommodations. The documentation must support the requested accommodations.

Please return completed form to SDRC. The information you provide will *not* become part of the student's academic records, but will be kept in the student's file at SDRC, where it will be held in accordance with federal laws regulating privacy of student records. This form may be released to the student at their request. In addition to the requested information, please attach any other information you think would be relevant to the student's academic adjustment. Please contact us if you have questions or concerns. Thank you for your assistance.

Student's Name: _____ Student's UCR Email:_____

Today's Date: _____ Initial Date of Diagnosis (below):_____

Date Student was Last Seen: _____ How often do you see the student:_____

What is the nature of the student's chronic health impairment? Please include ICD-10 Code and description.

- For **visual disabilities:** include the latest visual acuity/visual field examination results
- For **hearing disabilities:** include the latest audiogram examination results

Primary ICD 10 Code: _____ Description/Diagnosis _____
Secondary ICD 10 Code: _____ Description/Diagnosis _____

1. Please check the major life activities affected and the level of impact, due of the identified medical diagnosis.

Life Activity	**No Impact**	**Minimal Impact**	**Moderate Impact**	**Severe Impact**	**Don't Know**
Performing Manual Tasks (which hand?: ☐R L☐)					
Walking/Ambulation					
Prolonged ☐ Sitting / ☐ Standing					
Balance / Coordination					
Reaching					
Climbing					
Lifting					
Seeing					
Hearing					
Talking/Speaking					
Sustained Attention/Focus/Concentration					
Information Recall					
Fatigue/Stamina					
Breathing					
☐ Insomnia / ☐ Hypersomnia					
Dietary (specify nature and impact):					
Chemical allergies/sensitivities (specify nature and impact):					

2. What other specific symptoms/functional limitations are manifesting themselves at this time that might affect the student's academic performance?

3. Is the patient/student subject to flare-ups? ☐No ☐Yes; Please provide information on frequency, intensity, and duration of impact?

4. PROGNOSIS: How long do you anticipate that the student will be impacted by the above disability(ies)?
   Check One: ☐3 months or less ☐ ≈ 6 months ☐ ≈ 1 year ☐Permanent/Chronic ☐Unknown

5. What medications is the student currently taking? How effective is the medication? How might side-effects, if any, affect the student's academic performance?

6. Is there anything else you think we should know about the student's disability?

CERTIFYING LICENSED PROFESSIONAL*

Printed Name: _____ Signature: _____

Physician's License Number: _____ Specialty:_____

Address: _____City_____State_____Zip_____

Telephone: _____Fax: _____

*Qualified diagnosing professionals are licensed physicians. Treating professionals who are practicing under the license of a physician, form have this form signed by the supervising physician's license.

The diagnosing professional must have expertise in the differential diagnosis of the documented condition and follow established practices in the field. In accordance with professional ethics, this form may not be completed by a family member.