UC RIVERSIDE | Student Disability Resource Center

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sdrc.ucr.edu

# CERTIFICATION OF TEMPORARY 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 submit the 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 accommodations. 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 temporary health impairment?**
Please include ICD-10 Code and description.

**DIAGNOSIS:** _____

**Prognosis**: What is the anticipated length of impact to the student's functional limitations?
Check One: ☐1 month or less ☐ ≈ 2 months ☐ ≈ 3 months ☐ ≈ 6 months or less

1. Please check which of the major life activities below are affected because of the temporary 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 | | | | | |
| Climbing | | | | | |
| Reaching | | | | | |
| Lifting | | | | | |
| Seeing | | | | | |
| Hearing | | | | | |
| Talking/Speaking | | | | | |
| Sustained Attention/Concentrating | | | | | |
| Information Recall | | | | | |
| Fatigue/Stamina | | | | | |
| Breathing | | | | | |
| Eating | | | | | |
| ☐ Insomnia / ☐ Hypersomnia | | | | | |
| Other Limitations: | | | | | |

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

3. Treatment Plan: How often will you be seeing the student for treatment of this diagnosis?
☐ No f/u appointments scheduled ☐ Specify frequency:_____

4. What medications have you prescribed the student? ☐ N/A, I do not prescribe medication
Please identify name of medication, effectiveness, and side effects that affect academic performance:

5. If mobility/ambulation is impacted, can personal mobility equipment (i.e., wheelchair, knee scooter, crutches) ameliorate the impact?
☐ YES; ☐ NO: why not?_____

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

CERTIFYING LICENSED PROFESSIONAL*

Printed Name: _____ Signature: _____

Practitioner's License Number: _____ Specialty: _____

Address: _____City_____State_____Zip_____

Telephone: _____Fax: _____

*Qualified diagnosing professionals are licensed physicians. 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 cannot be completed by a family member.