UC RIVERSIDE | Student Disability Resource Center

900 University Ave.
1228 Student Services Build.,
Riverside, CA 92521
P (951) 827-3861
https://sdrc.ucr.edu
Submit completed from to 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 (please sign this form before providing it to your mental health care provider to complete):
By signing below, I consent to allowing my health care provider to share any information relevant to my need for disability related accommodations, as shown on this form, with (personnel from the SDRC office) for the next 60 days.

Student Name (Print) _____(signature)_____Date_____
Student UCR email:_____

TO BE COMPLETED BY THE LICENSED PROVIDER (incomplete information may nullify this request):
Patient Name: _____ Today's Date: _____
Initial Date of Diagnosis (below):_____ Date of most recent appt: _____
Dates of treatment within the last 6 months for the above diagnosis:_____

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

DIAGNOSIS: _____

PROGNOSIS/DATE student is projected to return to normal activities**:** _____

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					

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

3. What medications is the student currently taking? How effective is the medication? How might side-effects, if any, affect the student's academic performance? ☐N/A, I do not prescribe medication.

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

5. If mobility/ambulation is impacted, students are welcome to bring their own personal mobility equipment, as the campus is physically accessible to wheelchair uses. If personal mobility equipment (i.e., wheelchair, knee scooter, crutches) can ameliorate the impact, please discuss with your patient their personal mobility equipment options.

   My patient is aware of their personal mobility equipment options.
   ☐ Not applicable; ☐ 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: _____

Physician's License Number: _____ **Specialty**:_____

Name of Practice:_____

Address: _____City_____State_____Zip_____

Telephone: _____Website/Email:_____

* Professionals conducting assessments, rendering diagnoses of the above mentioned temporary health impairment, and making recommendations for accommodations must be qualified and licensed to do so. Comprehensive training and relevant experience in differential diagnosis are essential. In accordance with professional ethics, **this form may not be completed by a family member**. Practitioners who function under a supervising physician / mental health professional license (e.g., PA, NP, Nurse, Psych Intern,…), must have this form signed by the licensed professional supervising their work.