UCLA - Office for Students with Disabilities

Box 951426 Los Angeles, CA 90095-1426
(310) 825-1501   (310) 825-9656 (fax)

Verification of Disability

Student name____Birthdate____________________

I am requesting academic support services through the Office for Students with Disabilities at UCLA. 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 Office for Students with Disabilities at UCLA to contact you if clarification is needed.

Student Signature____ Date _________________

Physician/provider name (print)____Title______________

License #______________________Phone_________________________Fax___________________________

Organization & address____

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1. Diagnosis(es)____Diagnosis date____________
2. Level of severity ☐Mild ☐Moderate ☐Severe
3. Duration ***(This section must be completely filled out for the student to receive services.)***

   ☐Permanent

   ☐Chronic/recurring *(Likely to last for duration of college attendance.)*

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

4. Please list procedures/assessments used to diagnose this student's condition.______________________

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5. What treatment and/or medications are currently being used?___________________________________

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6. What are the functional limitations or symptoms?____

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7. How does this condition (or effects of medication) limit this student's ability to learn or to meet the demands in a university setting?____

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This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Signature____ Date___________________________________

All information on this form will remain confidential.