

Disability Documentation Form for Students with Mobility Impairments and Other Functional Impairments Due to Medical Conditions

Disabled Students' Program

University of California, Berkeley
260 César E. Chávez Student Center
Berkeley, CA 94720-4250
Phone: 510-642-0518 (Voice/TDD)
Fax: 510-643-9686

The student named below has applied for services from the Disabled Students' Program (DSP) at UC Berkeley. In order for DSP to establish whether this student has a disability and to determine her/his eligibility for services, we will need your assessment and diagnosis of this student. A disability is defined as a physical or mental impairment that limits one or more major life activities such as those delineated below. You can fax or mail the form to us at the address listed on this form. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

Student's Name: _____

Date: _____
 / /
 Month Day Year

1. What is the diagnosis/impairment?

2. What is the date of diagnosis/impairment?

3. Is the patient/student currently under your care?

4. When did you last see the patient/student?

5. Major Life Activities Assessment: Please check which of the major life activities listed below are affected because of the impairment. Please indicate level of limitation.

Life Activity	1–Negligible	2–Moderate	3–Substantial
Talking			
Hearing			
Breathing			
Standing			
Working			
Reaching			
Lifting			
Sitting			
Walking			
Seeing			
Writing			
Performing Manual Tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Interacting with Others			
Caring for Oneself			
Other			

6. What are the **specific functional limitations** resulting from the impairment's impact on the major life activities identified above (i.e., unable to lift more than 10 lbs.; unable to keyboard more than 10 minutes out of 60 minutes)?

7. Please attach any other supporting information (e.g., neurological or psycho-educational test reports, etc.)

8. Medications, effects, and possible side-effects:

9. If student is currently undergoing treatment, please describe the treatment and how treatment may affect the student in a post-secondary setting.

10. Are the functional limitations permanent? If not, anticipated date of resolution?

Certifying Medical Professional

Signature of Medical Professional

Date

Medical Professional's Name (printed) and Title

License No.

Address

Telephone No.

City, State, Zip

Fax