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 Chávez Student Center
Berkeley, CA 94720-4250
Phone: (510) 642-0518 (voice); (510) 642-6376 (TTY)
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 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.
For more information on DSP visit our website at dsp.berkeley.edu.

Student's Name: _____ UC Berkeley Student ID # _____ **(Required)**

Date of Birth: _____
Month Day Year

1. What is the diagnosis/impairment?

2. What is the date of diagnosis/impairment?

3. Major Life Activities Assessment: Please use a checkmark to indicate the disability's impact, if any, on the activities listed below, and describe the impact if appropriate.

Life Activity	**No impact**	**Moderate impact**	**Severe Impact**	**Don't know**	**Please describe if moderate or severe impact**
Walking (e.g. how far/long can student walk**,** use of mobility devices such as wheelchair, etc.)					
Standing (e.g., duration)					
Sitting (e.g., duration)					
Performing manual tasks (e.g., reaching, manipulating materials & lab equipment, etc.)					
Writing/Keyboarding (e.g., unable to keyboard more than 10 min., unable to handwrite, etc.)					
Speech Impairment					
Breathing					
Sleeping (or attach most recent sleep study)					
Caring for oneself (e.g., personal care, laundry, household tasks, etc.)					
Hearing (or attach most recent audiogram)					
Vision (or attach most recent eye exam)					
Other					

4. Please describe the effect of the medical condition, including side effects such as chronic fatigue and/or pain symptoms, on academic performance (e.g., concentration, reading, thinking, learning, etc.) and attendance.

5. Please list medications and possible side effects on academic performance and attendance.

6. If student is undergoing treatment, please describe how treatment (e.g., frequency of treatments, side effects of treatments, etc.) may affect student's academic performance and attendance,

7. Will the functional limitations last for the duration of the student's matriculation at Berkeley?
   Yes_☐_ No_☐_
8. If functional limitations fluctuate, how frequently did the student experience flare-ups within the past 12 months or since onset of diagnosis?

9. When and/or how often should the student be evaluated? Or, if limitations are not permanent, when will the injury be resolved?

10. Please attach any relevant supporting documentation (e.g., sleep studies, eye exams, audiograms, etc.). (over)

Certifying Medical Professional

_____	_____
Signature of Medical Professional	Date
_____	_____
Medical Professional's Name (printed) and Title	License Number
_____	_____
Address	Telephone Number
_____	_____
City, State, ZIP	Fax

I request that the information above be provided to DSP in order to determine my eligibility for the program and to obtain program services.

_____

Signature of Student Date

I authorize DSP and University Health Services to coordinate relevant information when necessary to support the efficient provision of DSP services and health care services on my behalf. This authorization will remain valid for the duration of my time as a student at UC Berkeley. I understand I may revoke this authorization at any time by submitting a written request to revoke to Disabled Students Program or University Health Services.

_____

Signature of Student Date