

**UNIVERSITY OF CALIFORNIA
HASTINGS COLLEGE OF THE LAW**

Office of the Disability Resource Program

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Disability Documentation Form for students with:

Mobility Impairments

Other Functional Impairments Due to Medical Conditions

Temporary Disability

Date (mm/dd/yyyy):

Name of Student:

Dear, Medical Professional:

The student whose name appears above has applied for services from the Disability Resource Program at UC Hastings. In order for DRP 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 in our letterhead or email DRP@uchastings.edu. If you prefer, you can answer these questions in a signed and dated letter on your professional letterhead.

1. What is the diagnosis/impairment:

2. Date of diagnosis/impairment (mm/dd/yyyy):

3. Is the patient/student currently under your care? Yes_ No _

4. When did you last see the patient/student (mm/dd/yyyy)?

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seeing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performing Manual Tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Learning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reading	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memorizing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interacting with Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring for Oneself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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: Is the student taking medications? Yes_ No _
If yes, list effects and possible side-effects.

9. If the 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? Yes_ No_ If no, anticipated date of resolution?

11. What accommodations do you recommend? (Please include academic adjustments).

Signature of Medical Professional

Date

X

Medical Professional's Name (Printed License No.)

Address:

Telephone:

Fax: