UC SAN DIEGO EXTENSION
Student Services

Practices for the Documentation and Accommodation of Students with Deaf/Hard of Hearing Disabilities

Dear UCSD Extension Student:

Please complete the top portion of the Verification of Disability form (see below) and take it to your medical provider to complete the remainder of the form. The verification form can be submitted by either yourself or your medical provider. Directions for submitting the completed form to UC San Diego Extension are listed below.

Thank you.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Dear Healthcare Provider:

UC San Diego Extension Student Services has received an accommodation request from a deaf and/or hearing impaired student. In order to determine eligibility and to provide services, we require documentation of the student's hearing disability.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to appropriate 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 disability in and of itself does not automatically qualify an individual for accommodations. The documentation must also support the request for accommodations and academic adjustments.

After completing this form, please sign it, and mail or FAX it to us at the address listed below. The information you provide will not become part of the student's educational records, but will be kept in the student's file at UC San Diego Extension Student Services, where it will be held strictly confidential. A copy of 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 adjustment. Feel free to contact us if you have questions or concerns.

UC San Diego Extension
Attn: Disabled Student Services Coordinator
9500 Gilman Drive, M/C 0176-H
La Jolla, CA 92093-0176
FAX: (858) 534-8527

Thank you for your assistance.

A copy of an audiogram performed within the last 3 years must accompany this form. If a current audiogram is not available, please provide justification as to why current testing is not necessary for this student’s diagnosis.
Verification of Deaf/Hard-of-Hearing Disability

To Be Completed By Student

Student Name: ___________________________________________ Extension Student ID#: _U-___________

I am requesting academic support services through UC San Diego Extension Student Services. They require current and comprehensive documentation of my disability/medical condition prior to receiving services through Extension. Please respond to the following questions as soon as possible and return to me or send by mail or fax. I authorize UC San Diego Extension Student Services to contact you if clarification is needed.

Student Signature: ___________________________ Date: __________

Treating Physician/Provider Name (Please print): __________________________________________________________

Phone: (____)_________________ FAX: (____) ________________

Address: ____________________________________________________________________________________________

To Be Completed By Treating Physician/Provider

This form must be completed by the Health Care Professional listed above.

Diagnosis(es): ___________________________________________ Diagnosis Date: __________________________

Level of severity: □ Mild □ Moderate □ Severe

Duration: □ Permanent □ Chronic/recurring (Likely to last for duration of attendance)

□ Temporary Date disability will end: _________________ (Accommodation not necessary after this date.)

Clearly describe this individual's medical impairment:

_____________________________________________________________________________________________
_____________________________________________________________________________________________

Please list procedures/assessments used to diagnose this student’s condition:

_____________________________________________________________________________________________
_____________________________________________________________________________________________

Specify functional limitations on the individual's ability to perform or participate in an academic setting (i.e. participation in online courses with audio/video, participation in seminars/discussions, oral examinations etc.)

_____________________________________________________________________________________________
_____________________________________________________________________________________________

Provide a description of current treatment(s) and/or medications being used with anticipated effectiveness in minimizing the impact of the impairment:

_____________________________________________________________________________________________
_____________________________________________________________________________________________

How does this condition (or effects of medication) limit this student’s ability to learn or to meet the demands in university-level setting?

_____________________________________________________________________________________________
_____________________________________________________________________________________________

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.

Physician Signature: ___________________________ License #: ___________________________ Date: __________

All information kept confidential as per UC PPM 160-2

Effective: July 6, 2010