Housing*Dining*Hospitality Clinical Documentation For Accommodation

UCSD Affiliate: (please circle) Faculty Staff Dependant:________________ Date:__________

Last Name:________________________________First Name:________________ Middle Initial: _______

UCSD ID Number____Date of Birth:________________

Dependent (if applicable) Last Name:____

First Name:________________ Middle Initial: _______ Date of Birth: :_______________________

Address:____

City: __________________________ State: ___________________Zip Code: ______________________

Phone: ( ) ______________________________ Email:____

Please forward this documentation onto a certifying professional to complete. A certifying professional is an individual who specializes in the area of the condition or disability. A certifying professional may not be a friend or relative to the individual being evaluated.

Name:____

Specialty:______________________________________

Address of Practice/Business:____

City: ____________________________State:___________________Zip Code: ______________________

License/Certification Number of State of Licensure ____

Date of initial contact with individual being evaluated: ______________ Last Contact:________________

Please provide a current diagnosis outlining any functional limitations related to this diagnosis. Please provide recommendations regarding the specific needs for housing accommodations and appropriate justification for the recommendations. This documentation must be prepared on your professional office stationary (prescription pad paper is not acceptable) and attached to this sheet.

Signature of Certifying professional: ____ Date:_____________

UCSD AFFILIATE: RETURN COMPLETED FORM AND ATTACHED STATEMENT WITH ANY OTHER SUPPORTING DOCUMENTATION TO:

Rexanne Bowman Anderson
Special Programs Coordiantor
University of California at San Diego
9500 Gilman Drive #0541
La Jolla, California, 92093-0541

Office Use Only	Date Received:________________	Date Contacted:________________