Dongguk University Los Angeles
440 Shatto Place, Los Angeles, CA 90020
Tel : 213 487-0110
www.dula.edu

MEDICAL DISABILITY DOCUMENTATION FORM

To be completed by a certified medical professional.

In accordance with the Americans with Disabilities Act (ADA) of 1990 as amended, Section 504 of the Rehabilitation Act of 1973 (Section 504), Dongguk University Los Angeles (DULA) provides reasonable accommodations to students with disabilities. In order to do so, students should submit all accommodation requests to DULA Student Services Coordinator as the designated officer for disability services.

Students requesting accommodations should review the guidance provided by DULA Student Services Coordinator for documentation, but generally must submit documentation that clearly demonstrates that (1) the student has a physical or mental impairment, and (2) the impairment prevents the normal exercise of any bodily or mental functions (or can be shown to exist through accepted clinical or laboratory diagnostic tests), as compared to most people in the general population. A diagnosis of a disorder, or submission of an evaluation, does not automatically qualify an individual for accommodations. Appropriate documentation must be provided by a qualified professional, meet currency requirements, include diagnosis information as well as information about the functional limitations caused by the impairment, and support the request of specific accommodations. In some cases, DULA Student Services Coordinator evaluation may include review of documentation by an internal or external consultant engaged by DULA. Accommodations are determined through an interactive process that includes an intake interview.

This document requests information necessary to determine the impact of a medical disability on the student's ability to participate in the University's educational programs and to validate the need for accommodation(s). In instances where there are multiple diagnoses, including learning disabilities, ADHD or psychological disabilities, evaluators should consult DULA Student Services Coordinator for documentation requirements for those disabilities. A treating certified medical professional should complete this form or provide equivalent information on professional letterhead.

Designated University Officer for Disability Services:

DULA Student Services Coordinator
440 Shatto Place, 2nd Floor, Los Angeles, CA 90020
Phone: 213-487-0110 ext. 406, Email: AC@dula.edu

dongguk UNIVERSITY LOS ANGELES
School of Oriental Medicine

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STUDENT INFORMATION

Full Name: ______________________ Legal Name (if different): ___________________

DULA Student ID: _______________

Enrollment Status (choose that apply):

- ☐ Current MSOM Program Student __ Active __ On Leave of Absences
- ☐ Current DATM Program Student __ Active __ On Leave of Absences
- ☐ Current DAOM Program Student __ Active __ On Leave of Absences
- ☐ Non-matriculating Students __ Active __ On Leave of Absences
- ☐ Admitted into the program but undecided

DIAGNOSIS

Diagnosis	Diagnosis Date (MM/DD/YYYY)	Date of Onset (MM/DD/YYYY)
	__ / __ / ____	__ / __ / ____
	__ / __ / ____	__ / __ / ____
	__ / __ / ____	__ / __ / ____
	__ / __ / ____	__ / __ / ____
	__ / __ / ____	__ / __ / ____

Symptom and treatment history:

____
____
____
____
____
____
____
____
____
____
____

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CURRENT TREATMENT

Is the student currently in treatment with you? ___ YES ___ NO

If yes, what is the visit frequency? ____________________ Total Visit: _______

Name of additional treating professional if known: ______________________________

If known, what if the visit frequency? ____

Current symptoms (indicate severity: Substantial (S), Moderate (M), Mild (MI), Remission (R)):

____

____

____

____

Current treatment plan:

____

____

____

____

Prognosis (Please give anticipated progression, duration, stability):

____

____

____

____

Current prescribed medications	Side effects impacting student

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FUNCTIONAL IMPACT

Please provide detail on the functional impact on ability to complete course work or other program requirements as well as activities outside the classroom. Please use additional paper for more information.

____
____
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____
____

Please provide recommendations for accommodations to support the student and include the rationale for those recommendations. Please use additional paper for more information.

____
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____

CERTIFYING PROFESSIONAL

Name: ___________________________________ Specialty: ____________________

Email address: _________________ License (Type and Number): _______________

Address: ____

Phone Number: ________________________ Fax Number: _______________________

I certify that the student named above has given me permission to release all information contained on this form for the purpose of considering eligibility for accommodations, modification or adjustments based on disability.

Signature: __________________ Date (MM/DD/YYYY): ___ / ___ / _____