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 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:

Ivonne G. Montano
Housing Liaison
University of California at San Diego
9500 Gilman Drive #0541
La Jolla, California, 92093-0541

Office Use Only

Signature of Housing Liaison:_____ Date Received:_____