



OSU CENTER FOR HEALTH SCIENCES
Student Disability Accommodations Request--Provider Form

Name of Requesting Student: _____

Name of Provider and Credentials: _____ **Contact No.** _____

Diagnosis(es) for which accommodations are being requested:

Date last seen by this provider for the diagnosis(es) for which the student is requesting accommodations:
_____.

Date of Diagnosis(es) (if multiple, please identify which diagnosis you diagnosed on which date):

Diagnosis(es) based on (Check all that apply):

- ☐ Clinical Interview ☐ Psychometric Testing ☐ Diagnostic Study ☐ Physical Exam
☐ Other (please explain): _____

Date(s) diagnostic criteria were performed: _____

How does this condition (s) substantially limit a major life activity of student (e.g., thinking, communicating, concentrating, learning, reading, sleeping, etc.)? Specify the impacted activities and how the diagnosis(es) affect(s) such activities:

Describe how diagnosis(es) affect(s) the student's academic performance:

Provider's suggestions for accommodations (check all that apply):

- ☐ Extra time for taking tests (please specify time required): _____
☐ Quiet, low distraction room
☐ Other please describe) _____

Provider Signature: _____ **Date:** _____

To be Completed by Student: I hereby authorize **Brenda J. Davidson** or other OSU-CHS designee to discuss my medical condition with the following individual(s): _____
as it relates to this request for disability accommodation.

Student Signature: _____ **Date:** _____

Please attach additional pages if necessary to provide further explanation