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 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: _____

Does this condition(s) substantially limit a major life activity of student (e.g., thinking, communicating, concentrating, learning, reading, sleeping, etc.)?
□ No
□ Yes–**If yes, please 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 Angela Bacon 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