

OFFICE OF DISABILITY SERVICES

Student Name:	CSU ID:		DOB:
I am requesting disability support se (ODS) at Cleveland State University comprehensive documentation of my used to evaluate my eligibility for dis Please respond to the following quest can return the document to me direct the Office of Disability Services to contact the contact th	. The department y disability/medica ability related acceptions as soon as tily or submit it to	requires curre al condition as commodations possible. One ODS via ema	ent and s one of the criteria s and services. ce complete, you il or fax. I authorize
Student Signature:		Date:	
Health Care Provider Name (Print):			
Title:			
Phone: E	XT: F	- ax:	
Organization:			-
Mail Address:			

Note to Providers:

The information that you provide will NOT become part of the student's educational records, but it will be kept in the student's file at ODS, where it will be held strictly confidential.

The following information must be completed by the health care professional listed on the previous page.

liste	isted on the previous page.		
1.	Diagnoses:		
2.	Date of Diagnosis:		
3.	Current status of Condition(s): Circle Response		
	a. Activeb. Progressing		
	c. Controlled		
	d. In Remission		
	e. Other (explain)		
4.	Current level of Severity (Circle Response):		
	a. Mild		
	b. Moderate		
	c. Severe		
5.	How long is this condition(s) likely to persist? Be as specific as possible. (e.g. Lifetime, 1 Academic Year, During of Academic Program Enrollment, etc)		
6.	Please list procedures/assessments used to diagnose this student's condition.		
7.	What are the functional limitations or symptoms of this condition(s)?		

8.	What exacerbates this student's specific disability(ies)? Please be as specific and detailed as possible).
9.	How does the condition (and/or current treatment, including medications) impact the student's ability to learn or meet the demands of the university setting, clinical requirements, and/or ability to live in university housing?
10.	Identify any accommodations you believe may be necessary in order for the student to participate in university programs, activities, and services.
recen	nformation is current and accurate to the best of my knowledge based on my to evaluation of this patient or my review of records of a recent evaluation by a ed health care provider.
Signa	ture of Treatment Provider:
Printe	d Name:
Licens	se #:Date:
Disab you re inform	you for your assistance. You may fax or email your report to the Office of ility Serices at ODS@csuohio.edu or 216.687.2343. Please call 216.687.2015 if equire additional information. Please attach any additional reports or relevant nation (audiology reports, neuropsychological evaluations, etc). All information on with the Family Educational Rights and

this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).