Appendix III

CENTER FOR HEALTH SCIENCES
OKLAHOMA STATE UNIVERSITY

Student Accommodation Request – Provider Form

Name of Requesting Student: ______________________________

Name of Provider and Credentials**:** __________________________ Contact No.: _____________

Diagnosis(es) for which accommodations are being requested:

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Date of Diagnosis(es) (if multiple, please identify date of each diagnosis):

____

____

Evaluations that were used for the diagnosis(es) (check all that apply):
□ Clinical Interview □ Psychometric Testing □ Diagnostic Study □ Physical Exam
□ Other (please explain): ____

Date(s) evaluation(s) 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:

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____

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

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____

____

[see next page]

Provider's suggestions for reasonable accommodations (check all that apply):
□ Extra time for taking tests (please specify time required): ___________________________________
□ Quiet, low distraction room
□ Other (please describe): ____

Provider Signature: ____ Date: ____

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To be Completed by Student: I hereby authorize The Assistant Dean of Student Life 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