

**Florida State University
Office of Accessibility Services**

HEALTHCARE PROVIDER DOCUMENTATION FORM SUPPORTING ACADEMIC ACCOMODATIONS

PROVIDER: The Office of Accessibility Services/OAS at Florida State University/FSU complies with all federal and state disability laws to ensure equal access to educational programs, services, and activities for qualifying students with a disability. As the doctor/professional thoroughly familiar with this student's condition and functional limitations, this form serves to appropriately document your patient/client's current condition. Additionally, it will assist the OAS in determining proper and reasonable accommodations. Additional paper may be attached if the space provided is insufficient.

Student's Name: _____

1. Specific diagnosis/disability (include DSM-5 diagnostic code): _____

2. Date of diagnosis: _____

3. Expected duration of the condition: _____

4. Procedures/assessments used to diagnose this condition (**ATTACH COPIES** of any psychological evaluation used in making/confirming diagnosis):

5. Current severity of this condition: _____

6. Prescribed treatment and/or medications: _____

7. Description of the current functional impact of the disability on the student's academics. Please be sure to *connect the diagnosis to the functional impact*.

8. Known history of accommodations (if applicable): _____

9. Recommended Accommodations – please be sure to *connect the diagnosis to the recommended accommodations*: _____

CLINICIAN'S NAME (Printed): _____

CLINICIAN'S SIGNATURE: _____

CREDENTIALS: _____

SPECIALTY, IF ANY: _____

LICENSE/CERT. #: _____ STATE: _____ DATE: _____

*Please attach your business card.