HEALTHCARE PROVIDER DOCUMENTATION FORM
SUPPORTING ACADEMIC ACCOMMODATIONS

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: _________________________________________________________________
   ______________________________________________
   ______________________________________________

CLINICAN’S NAME (Printed): _______________________________________________________________________
CLINICIAN’S SIGNATURE: ___________________________________________________________________________
CREDENTIALS: ______________________________________________________________________________________
SPECIALTY, IF ANY: _________________________________________________________________________________
LICENSE/CERT. #: _________________________ STATE: ________ DATE: ______________

*Please attach your business card.