Cleveland State University
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OFFICE OF DISABILITY SERVICES

Student Name:_____ CSU ID: _____ DOB: _____

I am requesting disability support services through the Office of Disability Services (ODS) at Cleveland State University. The department requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability related accommodations and services. Please respond to the following questions as soon as possible. Once complete, you can return the document to me directly or submit it to ODS via email or fax. I authorize the Office of Disability Services to contact you if clarification is required.

Student Signature:_____ Date: _____

Health Care Provider Name (Print): _____

Title: _____

Phone: _____ EXT:_____ Fax: _____

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.

Mailing Address: 2121 Euclid Ave, RW 210 • Cleveland, Ohio 44115-2214
Campus Location: Rhodes West 210• 2124 Chester Ave • Cleveland, Ohio
Telephone: (216) 687-2015 • Fax (216) 687-2343

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

1. Diagnoses:

2. Date of Diagnosis:

3. Current status of Condition(s): Circle Response

   a. Active ◯
   b. 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.

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

Signature of Treatment Provider: _____

Printed Name: _____

License #: _____Date: _____

Thank you for your assistance. You may fax or email your report to the Office of Disability Serices at ODS@csuohio.edu or 216.687.2343. Please call 216.687.2015 if you require additional information. Please attach any additional reports or relevant information (audiology reports, neuropsychological evaluations, etc). All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).