

# PEPPERDINE UNIVERSITY

Office of Student Accessibility

24255 Pacific Coast Highway  
Malibu, CA 90263-6500

T: 310-506-6500 F: 310-506-6776

CWID: \_\_\_\_\_

Student name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

*I am requesting academic support services through the Office of Student Accessibility at Pepperdine University. Pepperdine requires current and comprehensive documentation of my disability/medical condition. Please respond to the following questions as soon as possible and forward by mail or fax listed. Students: You may submit this form through secure email at attachments.pepperdine.edu.*

Physician/provider name (print): \_\_\_\_\_ Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Organization & address: \_\_\_\_\_

**This form must be completed by the Medical/ Mental Health Professional listed above.**

Diagnosis(es)/DSM Codes: \_\_\_\_\_ Diagnosis date: \_\_\_\_\_

Level of Severity:                      Mild                      Moderate                      Severe

Duration:            Permanent                      Chronic/recurring (Likely to last the duration of college attendance)

Temporary Date disability will end: \_\_\_\_\_ (Accommodations not necessary after this date)

What assessments/instruments were used to determine diagnosis? \_\_\_\_\_  
\_\_\_\_\_

What treatment and/or medications are currently being used? \_\_\_\_\_  
\_\_\_\_\_

What are the functional limitations or symptoms (due to disability or medication side effects)?  
\_\_\_\_\_  
\_\_\_\_\_

What accommodations are appropriate to compensate for the limiting functions mentioned above?  
\_\_\_\_\_  
\_\_\_\_\_

***This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient and/or my review of records.***

Physician/Therapist Signature

License #

Date