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