PEPPERDINE UNIVERSITY

Disability Services Office   24255 Pacific Coast Highway, Malibu, CA 90263-6500   T: 310-506-6500   F: 310-506-6776

CWID: ________________________

Student name: ______________________________   Birth date: ____________________

I am requesting academic support services through the Disability Services Office 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)? __________

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____

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

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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: __________