CHAPMAN
UNIVERSITY

Office of Disability Services | One University Drive ~ Orange, CA 92866 | (714) 516-4520 ~ FAX (714) 516-4550

Student name_____ Birth date_____

I am requesting academic support services through Disability Services (DS) at Chapman University. They require current and comprehensive documentation of my disability/medical condition. Please respond to the following questions as soon as possible and forward by mail, email or fax listed above (Attn: Disability Services). Direct/Confidential email address DS@chapman.edu

Physician/provider name (print):_____Title:_____

Phone: _____ Fax: _____

Organization & address: _____

This form must be completed by the Health Care Professional listed above.

Diagnosis(es) : _____ **Diagnosis date**_____

Level of Severity: Mild Moderate Severe

Duration: Permanent Chronic/recurring (Likely to last for 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)? _____

_____

_____

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 Signature_____License#_____ Date_____

All information on this form will remain confidential.