Disability Services and Diversity Office
OSU-Oklahoma City (OSU-OKC)
Student Center, Room 136
(405) 945-3385- (voice)
Fax: (405) 945-9127
okc.accessibility@okstate.edu
https://osuokc.edu/disability

Patient/Client Name ________________________________ Patient/Client Date of Birth ____________________

HEALTH CARE PROVIDERS: The information you provide on this form will be used as supporting information to determine reasonable accommodations for a student. Please return completed form directly to patient/client. If you have questions about this form, please contact our office at 405-945- 3385 or okc.accessibility@okstate.edu.

STUDENTS: Please return completed form to our office by emailing okc.accessibility@okstate.edu or scheduling an appointment to submit in-person.

1. What is the patient/client's primary diagnosis or primary diagnoses, if applicable? (If multiple medical conditions exist, please focus on what condition affects the patient/client most in their daily life activities.)

   ____
   ____
   ____
   ____

2. Current functional limitations associated with the primary disability/disabilities (how disability affects patient's functioning in major life activities, please specify severity as applicable):

   ____
   ____
   ____
   ____

3. What is the expected progression or stability of the disability?

   ____
   ____
   ____
   ____

4. General comments (optional):

   ____
   ____
   ____
   ____

Signature of Health Care Provider ____

Printed name of Health Care Provider ______________________________________

Date __________________________