PEPPERDINE UNIVERSITY

Student Name: _____
Campus Wide ID (CWID): _____
Date of Birth: _____

Pepperdine Accessibility Form

Note to student: *Please do not complete this form -- it must be completed by your treating clinician.*

Why has the student requested the qualified professional complete this form?

This request for information regarding my disability is being provided to you in connection with my application for academic support services from the Office of Student Accessibility (OSA) at Pepperdine University. OSA requires current and comprehensive documentation of my disability from a qualified diagnosing professional as part of the process to determine my eligibility for reasonable and appropriate academic adjustments based on functional limitations resulting from my condition. "Qualified diagnosing professionals" include licensed clinicians whose scope of training and experience include diagnosis and treatment of adults. These licensed clinicians are non-familial, follow established practices in the field, and are most often physicians, licensed psychologists, psychiatrists, social workers, or licensed therapists. For clinical assessments, the professional conducting the assessments and rendering diagnoses must have comprehensive training with regard to the specific disability being addressed.

Please respond to the following questions as soon as possible and return to OSA by fax (310.506.6776) or request a secure link at student.accessibility@pepperdine.edu.

Health Care Provider Information

Name:	Title:
License #:	Specialty:
Address:	
Phone:	Fax:

Medical Information – If this is your first time seeing this patient, please review the patient's records, if available, in order to provide the following information. The student may also have their primary care physician provide this information.

The following questions are to be answered by the qualified professional identified above. If you have recently begun treating this student, you may find that you do not yet have sufficient information to respond to the questions on this form. If you have not had recent clinical contact with the student, or otherwise find that you cannot effectively complete this form, please inform the student directly.

If you would like to share any related pertinent information, please do so here:

Please Note: Depending on the nature of the condition, OSA may require a comprehensive report (ie cognitive achievement test scores, audiogram, and/or other relevant information to determine reasonable accommodations)

Clinical/Medical Provider's Signature: Date:

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Diagnostic Information

Please list the diagnosis/es and the relevant DSM-5 or ICD-10 codes:

Do you believe that the requesting person meets the definition of having a disability as defined by the ADA, as described here: https://adata.org/faq/what-definition-disability-under-ada

Yes ☐ *No* ☐ *Unsure* ☐

Severity of the diagnosis/es: *Mild* ☐ *Moderate* ☐ *Severe* ☐

Nature of the diagnosis/es: *Acute* ☐ *Episodic* ☐ *Chronic* ☐ *In Remission* ☐

Prognosis: How long do you anticipate this student's academic performance will be impaired by her/his disability?

How was this diagnosis determined? (Please check all that apply and attach/fax diagnostic report of assessment(s) if available) *(Please attach/fax diagnostic report of assessment(s) if available)*

☐ *Structured or unstructured interviews with student*

☐ *Neuropsychological testing (attach documentation)*

☐ *Interviews with other persons (i.e.parent, teacher, therapist)*

☐ *Psychoeducational testing (attach documentation)*

☐ *Behavioral observations*

☐ *Other (please specify in attachment)*

What historical data was considered in making the diagnosis or accommodation recommendation? Please describe any pertinent history about this student/client:

Contact with student:

1. Onset of condition: _____
2. Date of first contact with student (mm/dd/yyyy): _____
3. Date of most recent contact with student (mm/dd/yyyy): _____
4. Please describe the frequency of your contact with this student/client (# of therapy sessions, if applicable): _____

Academic Accommodation Information

A diagnosis does not, in and of itself, qualify a student for accommodations under the the Americans with Disabilities Act Amendments Act (ADAAA). Accommodations are not based on the student's diagnosis, but instead are designed to address the barrier(s) caused by any functional limitation(s) related to the condition. Reasonable accommodations are modifications or adjustments to the policies, environment, practices and/or procedures that enable individuals with disabilities to have an equal opportunity to participate in an academic program without fundamentally altering that program or its goals; they are not designed to guarantee student success.

If more space is required, please attach additional pages to this form.

Please indicate your recommendations for accommodations within the post-secondary environment, as supported by the reported functional limitations and their impact on this student.

Accommodation:

Rationale:

Accommodation:

Rationale:

Accommodation:

Rationale:

Accommodation:

Rationale:

Accommodation:

Rationale:

Does the student require adaptive equipment to perform routine tasks? (if so, please specify):

If you feel that you are unable to recommend any specific accommodations as requested above, please explain why:

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Description of Functional Limitations: This section must be completed by the medical provider. Failure to do so will result in an incomplete application for the student. A functional limitation is a restriction in the ability to perform an action or activity in the manner or within the range considered 'normal' and which is attributable to impairment.

☐ **If no functional limitations identified at this time, please indicate by checking this box.**

Cognition/Learning

Major Life Activity	**None**	**Mild**	**Moderate**	**Severe**	***Please include an explanation of limitations if moderate or severe impact is indicated. Include limitations related to medication side effects.***
Thinking/Concentrating	☐	☐	☐	☐	
Information Processing	☐	☐	☐	☐	
Memory	☐	☐	☐	☐	
Sustained Reading	☐	☐	☐	☐	
Sustained Writing	☐	☐	☐	☐	
Sustained Focus	☐	☐	☐	☐	
Executive Functioning	☐	☐	☐	☐	
Learning	☐	☐	☐	☐	
Course Engagement	☐	☐	☐	☐	

Communication, Senses, and Movement

Major Life Activity	**None**	**Mild**	**Moderate**	**Severe**	***Please include an explanation of limitations if moderate or severe impact is indicated. Include limitations related to medication side effects.***
Communicating	☐	☐	☐	☐	
Seeing	☐	☐	☐	☐	
Hearing	☐	☐	☐	☐	
Listening	☐	☐	☐	☐	
Walking, Standing, or Bending	☐	☐	☐	☐	
Sustained Focus	☐	☐	☐	☐	

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Activities of Daily Living/Physical Health

Major Life Activity	None	Mild	Moderate	Severe	***Please include an explanation of limitations if moderate or severe impact is indicated. Include limitations related to medication side effects.***
Sleeping					
Eating					
Immune System Functions					
Self-care					
Speaking					
Bladder/Digestive					
Respiratory/Breathing					

Additional areas

Major Life Activity	None	Mild	Moderate	Severe	***Please include an explanation of limitations if moderate or severe impact is indicated. Include limitations related to medication side effects.***
Other:					
Other:					
Other:					

Thank you for your cooperation. You can fax (310.506.6776) this completed document or request a secure link at student.accessibility@pepperdine.edu.
Please call 310.506.6500 if you require additional information. Please attach any reports.