

Student Disability Services

Healthcare Provider Form					
Today's Date	Olympic College Student ID Number Date of Birth (mm/		(mm/dd/yyyy)		
Student's Last Name		First Name	,	Middle Initial	
This section to be completed by a qualified licensed and certified healthcare professional					
If condition is temporary, ple	ase indicate expected	duration:			
1. What is the specific diag	<u>-</u>	•	vant DSM-V or	ICD code and	
2. Please describe the cur Student's dominant wri	• •	stated diagnosis(es) this st	udent experie	nces. For example,	
3. If the student experience the frequency and dura		of their condition, please d and the care plan for mana			

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4.	How does the diagnosis(es) significantly affect the student's academic performance?
	If medication is used for treatment purposes, how does it significantly affect the student's academic performance?
В	sy signing below, I am verifying that the diagnosis(es) and supporting information is accurate and that I am a

By signing below, I am verifying that the diagnosis(es) and supporting information is accurate and that I am a qualified professional who is licensed and certified to diagnose and treat the stated conditions. Printed Name of Certifying Professional Title License Number Signature Date Address City ST Zip Telephone (include area code) Fax (include area code)

Student Disability Services (formerly Access Services)

Building 4, Room 205 1600 Chester Avenue Bremerton, WA 98337-1699

Phone: (360) 475-7540 | Confidential Fax (360) 475-7436

Email: <u>DisabilityServices@olympic.edu</u> olympic.edu/StudentDisabilityServices

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