OLYMPIC COLLEGE

Student Disability Services

Healthcare Provider Form

Today's Date	Olympic College Student ID Number	Date of Birth (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, please indicate expected duration:

1. What is the specific diagnosis/health condition? Please provide the relevant DSM-V or ICD code and severity level of each (mild, moderate, severe).

2. Please describe the current symptoms of the stated diagnosis(es) this student experiences. *For example, Student's dominant wrist is immobilized.*

3. If the student experiences episodic flare-ups of their condition, please describe any triggers of episodes, the frequency and duration of the episodes, and the care plan for management/recovery of the episode.

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4. How does the diagnosis(es) significantly affect the student's academic performance?

5. If medication is used for treatment purposes, how does it significantly affect the student's academic performance?

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)
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