Medical Provider-Recommended Educational Accommodations

FOR ONLY Medical Providers to complete. Please fill out this form based on current information known to you of this individual. When completed, please fax to the private number of the University of Hawaii at Hilo Disability and Access Services: (808) 932-7768.

Student

Name:_____ Student ID _____

Diagnosis

□ DSM □ ICD

Diagnosis (Please List All))

Please respond to the following

The length of time to which the diagnosis manifested:

What are the symptoms of the diagnosis:

Please list any additional diagnoses/information:

Recommended Accommodations:

Signature

By signing below, you affirm that the information in this form is accurate to your most current knowledge.

Medical Provider Name:_____

Title: _____ Specialty Area:_____

Address:_____

Phone:_____ Fax:_____ Email:_____

Medical Provider Signature:_____ Date: _____