Office of Student Accessibility 24255 Pacific Coast Highway Malibu, CA 90263-6500 T: 310-506-6500 F: 310-506-6776

Physician/provider name (print): _____ Title: _____

Phone: _____ Fax: _____

Organization & address: _____

This form must be completed by the Medical/ Mental Health Professional listed above.

Diagnosis(es)/DSM Codes: _____ Diagnosis date _____

Level of Severity: ☐ Mild ☐ Moderate ☐ Severe

Duration: ☐ Permanent ☐ Chronic/recurring (Likely to last the duration of college attendance)

☐

What are the functional limitations or symptoms (due to disability