Cleveland State University
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# OFFICE OF DISABILITY SERVICES

Student Name: _____ CSU ID: _____ DOB: _____

I am requesting disability support services through the Office of Disability Services (ODS) at Cleveland State University. The department requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate my eligibility for disability related accommodations and services. Please respond to the following questions as soon as possible. Once complete, you can return the document to me directly or submit it to ODS via email or fax. I authorize the Office of Disability Services to contact you if clarification is required.

Student signature: _____ Date: _____

Health Care Provider Name (print): _____

Title: _____

Phone: _____ EXT: _____ Fax: _____

Organization: _____

Mail address: _____

**Note to Providers:**

The information that you provide will **NOT** become part of the student's educational record(s), but it will be kept in the student's file at ODS, where it will be held strictly confidential.

***Mailing Address:*** 2121 Euclid Ave, RW 210 • Cleveland, Ohio 44115-2214
***Campus Location:*** Rhodes West 210• 2124 Chester Ave • Cleveland, Ohio
Telephone: (216) 687-2015 • Fax (216) 687-2343

**The following information must be completed by the health care professional listed on the previous page.**

Physician's name (print): _____ Date:_____

Student's name:_____

Date of last visit: _____

1. Diagnoses:

2. Date of diagnoses: _____

3. Date of last contact with student:_____

4. What is the degree of the hearing loss? (**Please include a copy of the most recent audiogram)**

   ◯ a. Mild

   ◯ b. Moderate

   ◯ c. Severe

   ◯ d. Profound

5. Is the hearing loss expected to remain stable or is it expected to decline? If it is expected to decline, describe the expected progression of the hearing loss

6. Describe how this hearing disability may affect this student both academically and/or physically (functional limitations).

7. What means of communication has this student used in the past? Please describe the student's skill in the use of their communication skills.

8. What recommendations do you have for accommodations and/or auxiliary aids, (e.g. phonic ear, note-taker, real time captioning, sign language interpreting, etc.) in an academic setting? Please state your rationale for the accommodations and/or auxiliary aids you have recommended:

9. Are there any other associated disabilities? Please describe:

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified health care provider.

Signature of Health Care Provider: _____

Printed Name: _____

License #: _____ Date: _____

Thank you for your assistance. You may return your report to the Office of Disability Services via email at **ODS@csuohio.edu** or by fax at **(216) 687-2343**.

Please call **(216) 687-2015** if you require additional information. Please attach any additional reports or relevant information (audiology reports, neuropsychological evaluations, etc). All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA).