

Disability Resources and Services
Office of Institutional Engagement and Wellbeing
140 William Pitt Union
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Pittsburgh, PA 15260
Phone: 412-648-7890
Fax: 412-624-3346

drsrecep@pitt.edu www.drs.pitt.edu

Academic Accommodation Request Form

To be completed by a treatment provider. This form is offered as a guide.

DRS will review all formats of documentation submitted.

Directions for Treatment Provider:

- DRS will accept documentation from a treatment provider who has personal knowledge of the student, consistent
 with their professional obligations. So that we may better evaluate the request for this accommodation, please
 complete this form in its entirety and add additional, related information, as appropriate.
- The information completed on this form will be reviewed to determine:
 - 1. That the student is a person with a documented disability;
 - 2. That the requested accommodation is necessary to afford the student an equal opportunity to engage in the same activities, services, and benefits, use the same information, and have the same opportunity at the University to achieve as students without disabilities; and
 - 3. That there is an identifiable relationship between the disability and the requested accommodation.
- Return the Academic Accommodation Request form or alternate documentation to the student or directly to Disability Resources and Services (contact information on final page).

1.	Student Name:		
2.	Date of Birth:		
3.	Specific diagnosis/diagnoses. Include DSM-5 or ICD 10 diagnostic code.		
4.	Date of diagnosis	:	
5.	Date of most reco	ent evaluation:	
 Procedures/assessments used to diagnose this condition (attach copies of any eval to make/confirm diagnosis). 			

7.	Current impact of	of condition or the impact of the condition when active:			
8.	Prescribed treatment and/or medications:				
9.	Description of the current functional impact of the condition in the academic environment. Please be sure to connect the diagnosis to the functional impact.				
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	nent Provider who				
Name	(Please Print):				
Creder	ntials:				
License	e or Certification N	lumber:			
Phone:	:				
Signatu	ıre:				
Date:					

Submit completed documentation either directly to your patient or to DRS office.

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