



DISABILITY INFORMATION FORM

The student below has expressed interest in receiving academic accommodations at California State University, East Bay. In order to assist in determining appropriate academic accommodations, it is helpful for Accessibility Services to have the following information regarding the student's diagnosis and the resulting functional limitations.

Information on this form will be used in confidence for the educational benefit of the student. This information will be released to other parties only with the express written request of the student.

FIRST NAME MI LAST NAME NET ID PHONE

1. Description and date of diagnosis | diagnoses:

2. Please describe the functional limitations and severity of impact on the student in an educational setting
(Please note that accommodations will be determined based on specific functional limitations):

3. Please describe any side effects and functional limitations resulting from treatments or medications:

4. This/these diagnosis(es) is/are: Permanent | Chronic Temporary Until

MONTH | DAY | YEAR

CERTIFYING PROFESSIONAL

NAME

SIGNATURE

TITLE

LICENSE #

STREET ADDRESS

CITY

STATE

ZIP CODE

MAIN PHONE

FAX NUMBER

DATE

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CALIFORNIA STATE UNIVERSITY, EAST BAY 25800 CARLOS BEE BOULEVARD, HAYWARD, CA 94542 **CSUEASTBAY. EDU**