The Office of Disability Services (ODS) provides academic accommodations and services to students with **Temporary Disabilities**. Students seeking accommodations must provide appropriate documentation of their disability so that ODS can determine the student’s eligibility for accommodations; and if the student is eligible, determine appropriate academic accommodations. A **temporary disability** is one that will resolve within three to six months. For impairments requiring accommodations for six months or longer, please refer to our traditional accommodation process. To verify the disability and its severity, ODS requires the form below to be completed by the current treating licensed healthcare provider.

**Student name:**
Signed:____________________________________________Date:_____________________________
Name: (please print)________________________________________ BU ID:________________________

**For the current treating healthcare provider to complete:**
1. Diagnosis:_____________________________________________________
2. Date of your last clinical contact with student:_________/_________/________
3. The extent of the condition is: Mild Moderate Severe
4. Expected duration of temporary disability is: 1-3 months 3 – 6 months 6-12 months
5. Suggested Accommodations
   Please list the specific academic accommodations you suggest based on your assessment of the students clinical and academic history and diagnosis.
   __________________________________________________________________________
   __________________________________________________________________________
   __________________________________________________________________________
6. Please attach any relevant evaluation results or reports.

Thank you for your help in providing this information so that we may begin services as soon as possible. This form should be signed and returned to ODS at the address shown at the end of this document.

**Provider Information:**
I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.
**If filling out online, in lieu of signature, please click here to certify that the above statement is true.**
Y ☐ N ☐

Signature: ________________________________ Date: ________________________
Print Name and Title: ________________________________________________________
State of License______ : License Number: ________________________________
Address: _________________________________________________________________
Street or P.O. Box City State Zip: __________________________________________
Phone: ________________________________ Fax: _____________________________

**All documentation is considered confidential and can be mailed or faxed to:**
Office of Disability Services,
19 Deerfield St, second floor
Boston, MA  02215
Phone: 617-353-3658
Fax: 617-353-9646