

***Mailing Address:*** 2121 Euclid Ave, RW 210 • Cleveland, Ohio 44115-2214  
***Campus Location:*** Rhodes West 210 • 2124 Chester Ave • Cleveland, Ohio  
Telephone: (216) 687-ep5.

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? (
  - 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 \_\_\_\_\_ or by fax at \_\_\_\_\_.

Please call \_\_\_\_\_ 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).