Eastern Gateway Community College

Office of Accessibility Services

Medical Documentation Form

(Please complete and return via email to access@egcc.edu or fax to 740-266-0814)

Student name: _____ DOB _____

Provider: Name: _____

Phone number: _____ email: _____

Diagnosis: (Please provide a full clinical description as well as DSM/ICD code)

_____

_____

When was the student diagnosed? _____

Will the disability progressively get worse? _____ If Yes, please explain: _____

_____

How does the disability affect the student's learning? _____

_____

Academic accommodations being recommended: _____

_____

Other important information: _____

_____

Provider signature _____ Date: _____