Eastern Gateway Community College

Office of Disability Services

Medical Documentation Form

(Please complete and return via email to disabilityservices@egcc.edu)

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? _____

What evaluation methods/procedures were used to make the diagnosis? _____

_____

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

_____

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

_____

How does the disability affect the student's daily life? _____

_____

History of academic accommodations: _____

_____

Academic accommodations being recommended: _____

_____

Medications currently being prescribed for diagnosis: _____

_____

Other important information: _____

_____

Provider signature _____ Date: _____