MEDICAL DISABILITY VERIFICATION FORM

Disability Services may require information and supporting documentation in order to determine eligibility for reasonable accommodations. To assist with this process, please ask your licensed treating physician, medical provider, or clinician to .

Section 1: To be completed by the student

Campus/Location: ___________________ ***Program:*** ___________________***Degree:***_________________________

Term/Start Date: ________________________________***Student ID Number:***________________________________

Name of Student/Applicant: ____________________________________ ***Date:*** ______________________________

Home Address____

Phone ____ ***Cell*** ____

WCU Student Email____

Section 2: To be completed by licensed treating medical provider or other certifying professional

Statement of Diagnosis (es) or impairment: ____

Name of certifying official (please print): ____

Title: ___________________________***License number:*** ________________________________

Name of practice: ____

Street Address, City, and Zip code of practice: ____

____

Telephone number of practice: ____

Please return completed accommodation request form and if required, supporting documentation to the Campus Disability Services Coordinator for consideration.