REQUEST FOR DOCUMENTATION OF DISABILITY

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RETURN COMPLETED FORM TO:
STUDENT DISABILITY SERVICES
FILIPPI ACADEMIC HALL, RM 190

P.O. BOX 3326
MORAGA, CA 94575-3326

OFFICE: (925) 631-4358 FAX: (925) 631-4164

PART I. TO BE COMPLETED BY THE STUDENT:

(If more than one physician is treating this condition, please provide a separate copy of this sheet to each).

PART II. TO BE COMPLETED BY THE APPROPRIATE TREATING AND LICENSED NON-FAMILIAL HEALTH CARE PROFESSIONAL: Please add additional pages as appropriate to fully describe condition, limitations, and/or recommendations.

CERTIFYING PROFESSIONAL & TITLE: (please print)	LICENSE #:

DIAGNOSIS & RELEVANT SYMPTOMS:

_____

_____

PART II. (CONTINUED) PLEASE INDICATE THE IMPACT OF THE DISABILITY AND /OR ITS TREATMENT.

	N / A	MODERATE IMPACT	SEVERE IMPACT	DESCRIBE IMPACT IF MODERATE OR SEVERE:
Treatment / Medication Side Effects				[redacted]
Pain				