MCC Mohave Community College

Disability Services

Request for Medical Information

Section 1: Student Section

_____

Student Name

_____ _____

Current Address Phone Number

_____

City State Zip Code

AUTHORIZATION FOR RELEASE OF INFORMATION REGARDING DISABILITY

I hereby authorize _____ (Physician, Psychologist, Psychiatrist, Educational Diagnostician, and/or other Certified Professional) to release any information requested on this form for the purposes of documentation. By signing this form, I understand that once this petition has been processed, I may be required to provide additional documentation, on a case-by-case basis, of changes in my condition.

I understand that Mohave Community College has no obligation to provide accommodations until appropriate documentation has been received by the Office of Compliance. I hereby authorize Mohave Community College officials (members of the Office of Compliance) to verify, discuss, transmit or release on a "need to know basis" the contents of this petition with my physician, psychologist, diagnostician, practitioner, and/or other authorized Mohave Community College personnel. This document will be treated as a confidential record for purposes of documentation of a disability.

_____ _____

Student Signature Date

MCC Mohave Community College

Disability Services

Request for Medical Information

Section 2: Both Sides Completed by the Physician, Psychologist, Diagnostician or Other Practitioner

(Please refer to section 1 for student authorization to release the following information)

To the Physician, Psychologist, Audiologist, Diagnostician, and/or other Certified Professional: The student has informed Mohave Community College that his/her condition presents or may present a limitation to a major life activity as defined in Section 504 of the Rehabilitation Act and/or the Americans with Disabilities Act. This limitation may require accommodations for the completion of an academic program. We would appreciate receiving sufficient information from you in order to determine the limitations and appropriate accommodations in accordance with state and federal laws.

1. Please provide a diagnosis and the limitations of the condition or health issue:

_____

_____

_____

2. Prognosis: The condition is

☐Permanent
☐Temporary

If Temporary, for how long and is it subject to change?

_____

_____

_____

3. Is the condition under control?
☐Yes
☐No

4. When was the student first seen by you for this condition?

_____

_____

5. Can the student perform essential academic functions without threat to the health or safety of self and others?
☐Yes
☐No

MCC Mohave Community College

Disability Services

Request for Medical Information

6. Is there any medication or side effect(s) from medication that might affect academic performance?
☐Yes
☐No

If yes, explain how:

_____

_____

7. Class attendance is an essential function, does the condition affect the student's class attendance?
☐Yes
☐No

If yes, explain how:

_____

_____

I hereby certify that the information provided is true and correct to the best of my knowledge.

Certified Professional Print Name: _____

Degree/Specialty: _____

Mailing Address: _____

City, State, Zip: _____

Office Phone/Fax: _____

Certified Professional Signature: _____

Date: _____

Please send this completed form and any additional information to:

Disability Services
Mohave Community College
3400 Highway 95
Bullhead City, AZ 86442
Fax: (928)704-4164