

**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 Center for Teaching and Learning. I hereby authorize Mohave Community College officials (members of the Center for Teaching and Learning) 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

**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:

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2. Prognosis: The condition is

- Permanent  
 Temporary

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

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3. Is the condition under control?

- Yes  
 No

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

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5. Can the student perform essential academic functions without threat to the health or safety of self and others?

- Yes  
 No

6. Is there any medication or side effect(s) from medication that might affect academic performance?

Yes

No

If yes, explain how:

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7. Class attendance is an essential function, does the condition affect the student's class attendance?

Yes

No

If yes, explain how:

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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:**

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