OFFICE of ACCESSIBILITY SERVICES
PITT COMMUNITY COLLEGE

PO Drawer 7007 • Greenville, NC 27835-7007 • Phone (252) 493-7595 • Fax (252) 321-4345 • Everett-114

DISABILITY VERIFICATION FOR PHYSICAL/MEDICAL/MOBILITY CONDITION

I, (STUDENT)_____ , hereby authorize the release of the following information for the purpose of determining my eligibility for academic accommodation, as based on the federal guidelines for the definition of a disability. If you have any questions, please contact **Office of Accessibility Services**, Pitt Community College
PO Drawer 7007, Greenville, NC 27835-7007.
PHONE: 252-493-7595 FAX: 252-321-4246

_____ _____ _____
Date Signature of Student Date of Birth

Diagnosis: _____

Date of Diagnosis: _____ Date of Last Visit: _____

Level of Severity: _____ Mild _____ Moderate _____ Severe

Does this condition interfere with one of the following major life activities? (Check all that apply)

_____ walking	_____ hearing	_____ seeing	_____ speaking	_____ caring for one's self
_____ lifting	_____ bending	_____ eating	_____ sleeping	_____ concentrating
_____ working	_____ learning	_____ manual tasks	_____ breathing	
_____ reading	_____ standing	_____ thinking	_____ communicating	

Please list appropriate accommodations needed to accompany the patient's loss of functioning in each activity:

ACTIVITY	ACCOMMODATION(S) SUGGESTED
_____	_____
_____	_____
_____	_____
_____	_____

_____ (X) Physician's comments continue on reverse side of this form.

_____ _____
Physician's Name (please print) Phone

_____
Address City State Zip

_____ _____
Signature Date