GENEVA COLLEGE

Student Success Center (SSC)

Medical Provider Form

To be filled out by the medical provider

I. Student

Name: Last _____First_____ Date of Birth _____
Home Phone _____ Cell Phone_____ E-mail _____
Address_____

II. Certifying Professional

Name_____
Professional Title _____Highest Degree_____
Phone_____ E-mail_____
Address_____
License/certification, number, and state: _____

III. Condition:

a. Date of first contact: _____ Date of last contact: _____
b. Please list relevant diagnosis(es):

Diagnosis(es)	Does this condition substantially limit a major life activity (yes, no, when active)?	Would you rate the disability/condition as being mild, moderate or severe?	Is the condition stable, variable, or progressive?

IV. NOTE: THIS SECTION MUST BE THOROUGHLY COMPLETED BY THE TREATING PHYSICIAN OR IT WILL BE RETURNED TO THE STUDENT FOR RESUBMISSION. AS A RESULT, ACCOMMODATIONS MAY BE DELAYED.

a. How will the limitations of the "disability/condition" affect the student's ability to function?

b. What conditions will cause the disability to manifest itself with greater intensity?

c. Please make *specific recommendations* for accommodations that this student should receive to have equal, appropriate and reasonable access to services and programs. (Please use the back of this form if additional space is needed.)

Signature: _____ Date: _____

Please return the form to: Geneva College | SSC Director | 3200 College Avenue | Beaver Falls, PA 15010