INITIAL REQUEST
FOR DISABILITY ACCOMMODATION
FORM B (Temporary Medical Condition)

1169 Edgewater Drive, Grundy, Virginia 24614. Tel: 276-935-4349
Email: bstanley@asl.edu

Student Information:

_____ _____
First Name Middle Initial/Name Last Name Date of Birth

By signing this Form, I hereby authorize the release of the information requested on this Form, and I request that all additional information or supporting documentation be attached to this Form and returned to me for submission to ASL.

_____ _____
Student Signature Date

The student named above has self-identified as a student with a temporary medical condition that requires accommodations. You have been identified as a qualified professional diagnosing and/or treating this temporary medical condition. You may choose to answer the questions on this Form or to attach a separate letter or report.

1. Please identify the student's temporary medical condition as well as the accommodation(s) recommended and the expected duration of this temporary medical condition.

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2. Name, address, telephone number, degree(s), title/occupation/specialty, licensing entity, and licensing number of professional completing this Form.

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_____

3. Date you last saw/treated this student. _____

4. Expected duration of medical condition. _____

_____ _____

Signature of Qualified Professional Date