

# FORM B

## Initial Request for Disability Accommodation Temporary Medical Condition



APPALACHIAN  
— SCHOOL OF LAW —  
OFFICE OF THE REGISTRAR

1169 Edgewater Drive  
Grundy, VA  
Fax: (276) 935-8261  
registrar@asl.edu

### Student Information

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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.

<input type="text"/>	<input type="text"/>
Signature	Date

The student named above has self-identified as a student with a temporary medical condition that requires accommodation. 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.

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

3. Date you last saw/treated this student.

4. Expected duration of medical condition.

<input type="text"/>	<input type="text"/>
Signature of Qualified Professional	Date