P.O. Box Jamestown, NC 27282
Phone: (336) 334-4822
(336) 454-1126
www.gtcc.edu

Documentation of Temporary Condition Verification Form

As the diagnosing professional, please fully complete all sections of this form. Additional reports, information, or narrative can be attached if appropriate.
Please note: All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

I, ___________________________________, hereby authorize the release of the following information to disAbilityAccess Services at Guilford Technical Community College for the purpose of determining my eligibility for services.

__________________________________ ____________________ _________________________
Student Signature Date of Birth Date of Request

TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

I. Diagnosis

Primary Diagnosis: ____

Date of Diagnosis: ____________________ Date of Last Evaluation: ____________________

What is the expected duration? ____

Secondary Diagnosis: ____

Date of Diagnosis: ____________________ Date of Last Evaluation: ____________________

What is the expected duration? ____

II.Treatment

Date of Last Visit: ____________________

How often do you provide treatment? ____

Prescribed Medication	Side Effects

III.Limitations/Restrictions

List below the limitations/restrictions caused by the medical condition, how often the limitations/restrictions occur, how long they last, and the severity of each. (e.g. difficulty walking, 24 hrs, moderate severity; no use of dominant hand, etc). 1. Restrictions/Difficulties

____

____

2. Frequency/Duration (daily, weekly, monthly, number of days, etc.)

____

____

____ 3.

Which services, if any, do you recommend? (This is for informational purposes only. If required, Guilford Tech will determine the appropriate services.)

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Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified professional who performed the evaluation and made the diagnosis.

Professional Credential Documentation (PLEASE ATTACH YOUR BUSINESS CARD TO THE DOCUMENT OR ANOTHER FORM OF IDENTIFICATION FOR THE STUDENT FILE.)

Name____

Address____

Title____

Professional Credentials_______________ Phone : _________________________

License/Certification number_____________________

Signature_____________________________________ Date_____________________

To expedite the process, you may fax a copy to **1-336-232-9803.** All documentation is confidential. In addition to faxing, please mail the signed, original form to:

Guilford Technical Community College:
disAbility Access Services
P.O. Box 309 Jamestown, NC 27282
Attention: ________________________