ANTIOCH COLLEGE

Request for Medical Information

Antioch College works to ensure equal access to the College's educational opportunities and offerings for students with disabilities. As defined by both Section 504 of The Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA), a disability is a "physical or mental impairment that substantially limits one or more major life activity."

Students requesting accommodations on the basis of a disability/substantial limitation must provide current documentation from a licensed health care professional in order to evidence their condition(s) and to support our understanding when making accommodation determinations. The information you provide will be used for this purpose. Please be as thorough as possible.

Licensed professionals may submit a letter in place of this form if it fulfills all requested information listed on this form. Letters must be submitted on the professional's letterhead, signed, dated, and include the professional's license number.

TO BE COMPLETED BY THE STUDENT

DATE: _____

STUDENT NAME: _____

ADDRESS: _____

_____

PHONE: (_____)_____

TO BE COMPLETED BY THE CERTIFYING PROFESSIONAL

CERTIFYING PROFESSIONAL: _____

TITLE: _____

LICENSE NUMBER: _____

OFFICE/AGENCY NAME: _____

OFFICE/AGENCY ADDRESS: _____

OFFICE/AGENCY PHONE: (_____)_____

1. Please state the student’s current diagnosis(es) as per the most recent Diagnostic and Statistical Manual (DSM). Otherwise, please explain how the student is substantially limited.

2. Please explain the nature, frequency, and severity of the symptoms the student experiences.

3. Please indicate how the student's current treatment regimen, medication, and presenting symptoms may affect the student’s academic functioning.

4. If temporary, please indicate the expected duration of the student’s condition/disability(ies).

5. If applicable, please indicate how the student's current behaviors, medication(s), and presenting symptoms may affect the student in their housing.

6. How long have you treated this student?

8. **Please attach any relevant medical documentation (e.g. clinical summaries, assessments/evaluations, treatment records, etc.).**

Signature of Certifying Professional Date

License Number

PLEASE RETURN THIS FORM WITH THE SUPPORTING DOCUMENTATION TO:

Student Success Services Coordinator
Antioch College
One Morgan Place, McGregor 209
Yellow Springs, OH 45387
OR:
Email to studentsupport@antiochcollege.edu
Fax to 937-319-0189