



MEDICAL DISABILITY VERIFICATION FORM

Disability Services may require information and supporting documentation in order to determine eligibility for reasonable accommodations. To assist with this process, please ask your licensed treating physician, medical provider, or clinician to _____.

Campus/Location: _____ **Program:** _____ **Degree:** _____

Term/Start Date: _____ **Student ID Number:** _____

Name of Student/Applicant: _____ **Date:** _____

Home Address _____

Phone _____ **Cell** _____

WCU Student Email _____

Statement of Diagnosis (es) or impairment: _____

Name of certifying official (please print): _____

Title: _____ **License number:** _____

Name of practice: _____

Street Address, City, and Zip code of practice: _____

Telephone number of practice: _____