Disability Support Services • 411 North Front Street • Wilmington, North Carolina 28401-3993
Phone (910) 362-7800 • Fax (910) 362-7113

DISABILITY VERIFICATION FOR PHYSICAL/MEDICAL/MOBILITY CONDITION

I, (STUDENT) _____ , hereby authorize the release of the following information for the purpose of determining my eligibility for academic accommodation, as based on the federal guidelines for the definition of a disability. If you have any questions, please contact **Disability Support Services**, Cape Fear Community College, 411 N. Front Street, Wilmington, NC 28401.
PHONE: 910-362-7800 FAX: 910-362-7113

_____ _____ _____
Date Signature of Student Date of Birth

Diagnosis: _____

Date of Diagnosis: _____ Date of Last Visit: _____

Level of Severity: _____ Mild _____ Moderate _____ Severe

Does this condition interfere with one of the following major life activities? (Check all that apply)

_____ walking	_____ hearing	_____ seeing	_____ speaking	_____ caring for one's self
_____ lifting	_____ bending	_____ eating	_____ sleeping	_____ concentrating
_____ working	_____ learning	_____ manual tasks	_____ breathing	
_____ reading	_____ standing	_____ thinking	_____ communicating	

Please list appropriate accommodations needed to accompany the patient's loss of functioning in each activity:

ACTIVITY	ACCOMMODATION(S) SUGGESTED
_____	_____
_____	_____
_____	_____
_____	_____

_____ (X) Physician's comments continue on reverse side of this form.

_____ _____
Physician's Name (please print) Phone

_____
Address City State Zip

_____ _____
Signature Date

Updated: 4/20/17