Accessibility Services
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DOCUMENTATION OF TEMPORARY ILLNESS

Student Name: _____

Address: _____

Diagnosis: _____

Current Prognosis:

_____
_____
_____
_____

Summary of the functional limitations of the diagnosis and the impact of medication and/or treatment on educational functioning. Please include the dates and/or length of time the student will be unable to attend classes.

_____
_____
_____
_____

Diagnostician's Name: _____

Diagnostician's Title/Credentials: _____

Diagnostician's Signature: _____

Date: _____