Davidson-Davie Community College

Temporary Medical Condition Accommodations Request

Davidson-Davie Community College is committed to creating an accessible and inclusive environment for all students.

Please complete all sections. Handwriting should be legible and clear. Incomplete forms will not be accepted.

Student Name:	Date:
Student ID #:	Student Address:
Term:	Phone Number:
Campus Email:	Alternate Email:

Medical Provider Information

Provider First Name:	Provider Last Name:
Name of Practice:	Practice Full Address:
Phone Number:	Fax Number:

Description of Condition Information (to be completed by Medical Provider)

Date of onset:	Expected Duration (months, days, etc.):
Restrictions (please list)	
Condition Description:	
Complications (if applicable):	

Description on how medical condition impacts academics

Date of estimated maximum medical improvement:	Current treatments:
Description of how impairment impacts academics:	
Recommendations for accommodations from a medical perspective (in detail):	
Most recent office visit:	**Next follow up date:**

***Please send any accompany relevant medical notes and/or letters in addition to this form.**

Please note any request for change(s) requires supporting documentation or completion of this form again from your medical provider.

Please return completed form to:

Demetria Nickens
Coordinator, Accessibility, Counseling, & Health Services

Davidson-Davie Community College
Office Location: Grady E. Love Learning Resource Center 2nd Floor, Suite 206
Mailing Address: P.O. Box 1287 Lexington, NC 27293
Phone: (336) 249-8186 ext. 6342
E- Fax: 1 (336) 738 - 3542

Medical Provider Signature:	
Date:	
Student Signature:	
Date:	

Date received by ACH Coordinator: _____

Date Approved: _____