P.O. Box Jamestown, NC 27282
Phone: (336) 334-4822
(336) 454-1126
www.gtcc.edu

As the diagnosing professional, please fully complete all sections of this form. Additional reports, information, or narrative can be attached if appropriate.
Please note: All information that you provide may be shared with this student unless clearly marked otherwise. Thank you for your assistance.

I, _____, hereby authorize the release of the following information to disAbilityAccess Services at Guilford Technical Community College for the purpose of determining my eligibility for services.

_____	_____	_____
Student Signature	Date of Birth	Date of Request

III.Limitations/Restrictions

List below the limitations/restrictions caused by the medical condition, how often the limitations/restrictions occur, how long they last, and the severity of each. (e.g. difficulty walking, 24 hrs, moderate severity; no use of dominant hand, etc). 1. Restrictions/Difficulties

_____

_____

2. Frequency/Duration (daily, weekly, monthly, number of days, etc.)

_____

_____

_____ 3.

Which services, if any, do you recommend? (This is for informational purposes only. If required, Guilford Tech will