RANDOLPH COMMUNITY COLLEGE | OFFICE OF STUDENT SUCCESS

Pregnancy / Pregnancy-Related Condition Verification Form

(Healthcare Provider Section – Title IX Compliance)

Section 1: Student Information

Student Name: _____

Student ID #: _____

Phone Number: _____

Email Address: _____

Section 2: Healthcare Provider Information

Provider Name: _____

Title / Specialty: _____

Clinic / Hospital: _____

Phone: _____

Email: _____

Section 3: Verification of Pregnancy-Related Condition

(To be completed by a licensed healthcare provider)

1. Pregnancy / Condition Confirmation: ☐ Confirmed ☐ Not Confirmed

2. Anticipated Due Date: _____

3. Recovery Timeline: _____

4. Recommended Supportive Services/Accommodations or Adjustments:

☐ Excused absences for medical appointments

☐ Modified attendance or remote learning option

☐ Physical activity restrictions

☐ Lactation support / private space for milk expression

☐ Frequent bathroom break

☐ Other (please specify): _____

5. Expected Duration of Accommodation (s) _____

Section 4: Confidentiality Statement

The information provided on this form is confidential and will only be used by the Title IX Office to determine appropriate accommodation for the student. No other medical information will be shared without the student's consent.

Section 5: Provider Signature

I certify that the information provided above is accurate to the best of my knowledge.

Licensed Provider Signature: _____ Date: _____