RANDOLPH COMMUNITY COLLEGE
Creating Opportunities. Changing Lives.

Office of Student Success
629 Industrial Park Avenue • Asheboro, NC 27205
336-633-0200 • www.randolph.edu

# Professional Medical Documentation Form

I, _____, give my consent for the provider _____
STUDENT NAME PROVIDER NAME

To release information to the Office of Student Success in Student Services at Randolph Community College. I authorize the person or organization to provide a summary of contacts, including medical, psychological, psychiatric, academic, social, and other relevant information.

_____ _____ _____
Student Signature Student ID # Date

**Professional Providing Documentation:**

Name: _____

Professional Capacity: _____License #_____

Agency or Practice Address: _____

_____

_____

Phone Number: _____ Email: _____ Date: _____

**Diagnosis/Diagnoses:** _____

_____

_____

Description of the current **status of the student**, including tests and results (test and results, where needed, maybe appended) and of **impact on the student's academic performance:**

_____

_____

_____

_____

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_____

**Description of expected stability or progression of disability:**

_____

_____

_____

_____

**RECOMMENDED ACCOMMODATION(S)—JUSTIFICATION FOR ACCOMMODATION(S)**
1

2

3

4

**To be completed by Professional Providing Documentation when the form is completed:**
**This form must be signed for the student to receive recommended accommodation.**

I certify that the following accommodation request is appropriate for the above student.

Name of Professional Providing Documentation (Print): _____

Date: _____

Signature: _____