



WESTMONT

Documentation Form for Students with Short-term Medical Conditions (For conditions lasting 6 months or less)

Date:

Student's Name:

Date of Birth:

1. What is the diagnosed impairment?
2. What is the date of impairment?
3. What is the duration of this medical condition? When is it expected to be resolved?
4. Please describe the effects of the medical condition, including side effects and/or pain symptoms on academic performance?

5. Recommendations for services:

Certifying Medical Professional

_____ date: _____
(signature)

(name printed)

Return to:
Office of Disability Services-Attn: Sheri Noble
955 La Paz Road
Santa Barbara, CA 93108
FAX to: 805-565-7244
Email: snoble@westmont.edu

For office use only:
_____ Student Intake Form _____ Documentation received