WESTMONT

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

Student's Name _____ Date _____

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:

Name (certifying medical professional) _____

Signature _____ Date _____

License number _____ State _____

Address _____

_____
(name printed)

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

_____
For office use only:

_____ Student Intake Form _____Documentation received