Pregnancy Related Title IX Accommodations Request/Medical Verification Form

Instructions for the student:

First: Complete Section #1

Second: Have your physician complete Section #2

Third: Return the form to the executive director in the Office of Civility:

Jonathan Rowe – South Campus
1531 Trinity Church Rd.
Concord, NC 28027
FAX: 704-216-3723

Section #1

I, _____, hereby authorize the release of the following information to the Office of Accessibility at Rowan-Cabarrus Community College for the purpose of determining my eligibility for Title IX accommodations.

_____	_____	_____
Student Signature	Date of Birth	Date of Request

Section #2

As the diagnosing professional, please fully complete all sections (I.-IV.) 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.

TO BE COMPLETED BY THE DIAGNOSING PROFESSIONAL

I. Diagnosis

Primary Diagnosis: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

What is the expected duration? _____

Secondary Diagnosis: _____

Date of Diagnosis: _____ Date of Last Evaluation: _____

What is the expected duration? _____

II. Treatment

Date of Last Visit: _____

How often do you provide treatment? _____

Prescribed Medication	Side Effects

III. Limitations/Restrictions:

List below the limitations/restrictions caused by the pregnancy/pregnancy related condition(s) and how long the limitations/restrictions will be in effect (e.g. may not drive for x weeks, complete bedrest for x days, etc.).

Please be **specific** with date ranges (ex: 10-1-19 through 10-21-19).

1. Restrictions/Difficulties:_____

   _____

   _____

   _____

   _____

   _____

2. List below any other dates/times that the student should be excused due to the stated condition for medical appointments, hospital visits, etc. Please be **specific** with dates and times:

   _____

   _____

   _____

   _____

   _____

Thank you for your cooperation in this matter. Your prompt attention will allow us to begin providing services as soon as possible. Incomplete or missing information can prevent or delay necessary services. This form must be completed and signed by the qualified medical professional who performed the evaluation and made the diagnosis.

IV. Professional Credential Documentation (**Please attach your business card to the document or another form of identification for the student's file**.)

Name: _____

Title: _____

Address: _____

Phone: _____

Professional Credentials: _____ License/Certification number: _____

Signature: _____ Date: _____

The documentation below this line will be completed by Rowan-Cabarrus Staff/Administrators

Name of Assessment of Accessibility Counselor: _____

☐ Approved _____ ☐ Not Approved _____
Signature Signature

Rationale if not approved:

_____

_____

_____