UNIVERSITY of HAWAI'I®
HAWAIʻI
COMMUNITY COLLEGE

Documentation of Disability

Student Name: ____ Date of Birth: ____________________

Diagnosis/Condition: ____

Date of Diagnosis/Condition: ____

Current Symptoms related to diagnosis/condition: ____

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Are the symptoms expected to last six months or longer? _______ YES _______ NO

If no, when do you foresee the symptoms to abate? ____

Substantial areas that impact daily functioning or education: _______________________________

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Ongoing medical treatment needed: ____

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1175 Manono St.
Hilo, Hawai'i 96720
Telephone: (808) 934-2825
Fax: (808) 934-2791
www.hawaii.hawaii.edu
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Any feedback or suggestions on reasonable accommodations for this diagnosis/condition: ____________

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Additional comments: ____

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Professional's Signature: ______________________________________ Date: ____________________

Print Name: ____

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