COLLEGE of SAINT ELIZABETH

Disability Services
Medical Request Form

Please print all information is a legible manner.

Name: _____

Student ID No.:_____

DOB: _____

Home Address:

Street: _____

City/State: _____

Residence Hall
_____

Room_____

Home Telephone: _____
Cell Telephone: _____ Email address:_____

Major: _____ Freshman Sophomore Junior Senior

Accommodation Requested (**be specific and attach relevant documentation**)

Diagnosis: _____

Diagnostician/Treating Physician or Mental Health Professional:
_____

Address: _____

Telephone number: _____

Email address: _____

_____ _____
Student Signature Date