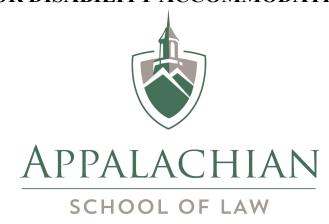
## INITIAL REQUEST FOR DISABILITY ACCOMMODATION



## FORM B – TEMPORARY MEDICAL CONDITION

1169 Edgewater Drive, Grundy, Virginia 24614. Tel: 276-244-1291

Email: cfox@asl.edu

Student Information:				
First Name	Middle Initial/Name	Last Name	Date of Birth	
	ional information or supp		rmation requested on this tation be attached to this l	
Student Signat	ture		Date	

The student named above has self-identified as a student with a temporary medical condition that requires accommodations. You have been identified as a qualified professional diagnosing and/or treating this temporary medical condition. You may choose to answer the questions on this Form or to attach a separate letter or report.

last revised: July 25, 2024

1. Please identify the student's temporary medical condition as well as the accommended and the expected duration of this temporary medical condition.			
2.	Name, address, telephone number, degree(s), title/occupation/specialty, licensing entity, and licensing number of professional completing this Form.		
3.	Date you last saw/treated this student.		
4.	Expected duration of medical condition.		
Signat	ture of Qualified Professional Date		

Appendix E