UNIVERSITY of HAWAI'I®
HAWAI'I
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Documentation of Disability

Student Name: _____ Date of Birth: _____

Diagnosis/Condition: _____

Date of Diagnosis/Condition: _____

Current Symptoms related to diagnosis/condition: _____

_____

_____

_____

_____

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: _____

_____

_____

_____

Ongoing medical treatment needed: _____

_____

_____

_____

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: _____

_____

_____

_____

Additional comments: _____

_____

_____

_____

Professional's Signature: _____ Date: _____

Print Name: _____

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