BRUNSWICK
COMMUNITY COLLEGE

Release of Information

I, (Student) _________________________________, hereby authorize the release of the following information for the purpose of determining my eligibility for academic accommodation, based on the federal guidelines for the definition of a disability. If you have any questions, please contact the Disability Services Office, Brunswick Community College, P. O. Box 30, Supply, NC 28462. Phone 910-755-7338 Fax 910-754-9609.

Date_________________ Signature of Student__________________________ SS#_____________

Julie Olsen
Disability Services Office

Diagnosis:____

How long has your patient retained this diagnosis? ______________________________ year(s)

What percentage of the time is your patient unable to perform a major life activity (i.e. learning, manual tasks, seeing, hearing, walking, breathing)?

Activity	% of incapacitation	% of time incapacitated
____________________________	_______________________	_______________________
____________________________	_______________________	_______________________
____________________________	_______________________	_______________________

Please list appropriate accommodations needed to accompany the student:

Activity	Accommodation(s) suggested
__________________________________	____
__________________________________	____
__________________________________	____
__________________________________	____

_____X Physician's comments continues of reverse side of this form. Thank You!

Physician's Name__________________________ Signature_____________________________

Address____Date________________