HEARTLAND COMMUNITY COLLEGE

# Temporary Medical Accommodation Verification

The student named below has made a request for Temporary Medical Accommodations (TMA) through Heartland Community College. TMA is designed for students who need support for temporary medical needs between one week and three weeks for the current semester of enrollment. To provide TMA services, we must have documentation of a temporary medical need that may be the cause of impairment to daily life functions. This form must be completed in full to proceed with the approval of Temporary Accommodations. This form can be submitted to Student Access and Accommodations Services via fax 309-268-7877 or email at accommodations@heartland.edu.

## TO BE COMPLETED BY THE STUDENT:

Student Name: _____ D.O.B. _____

Phone Number: (____)_____-_____ HCC Email: _____

***I hereby authorize the provider listed below to complete this form and provide information pertaining to my disability/diagnosis to Heartland Community College, Student Access and Accommodation Services Office.***

## TO BE COMPLETED BY A LICENSED PROFESSIONAL:

Name of provider (print): _____Phone Number: (____)_____-_____

This portion of the form is to be completed by a licensed professional qualified to make the diagnosis for which the student is seeking accommodations. It cannot be completed by a practicing family member of the student. ***This form is not valid unless completed in full,* please be specif. *A***ny concerns related to the authenticity of the form will be followed up on

**Temporary Disability/Diagnosis:** _____

**Description of the Temporary Disability/Diagnosis:**

_____

_____

**Functional Limitations due to the Temporary Disability/Diagnosis:**

_____

_____

**Services or Temporary Accommodations that you would recommend for the identified student:**

☐ **Excused absences** ☐ **Extended deadlines** ☐ **Remote Learning**

☐ **Scribe for written work** ☐ **Consideration of Incomplete** ☐ **Consideration for Withdraw**

☐ **Other:** _____

**Specific date range for accommodations (between one and three weeks) associated with the above-mentioned Temporary Medical Disability/Diagnosis:**

_____

***I clarify that all the information on this form is true and correct to the best of my knowledge. If any questions or concerns related to the information provided arise, I understand that I may be contacted by Heartland Community College to confirm the information provided.***

Signature of Licensed Professional: _____ Date: _____

Title or License Type and Number (print): _____