NORTH CAROLINA AGRICULTURAL AND TECHNICAL STATE UNIVERSITY

Request for Disability Related Excuse Verification

Office of Accessibility Resources

STUDENT'S NAME: _____

DATE OF APPOINTMENT: _____

1. The above-named person is under my care for the following disability related condition(s):

2. Explain how the condition would preclude this person from attending class:

3. When will this person be able to return to class?

Name of Diagnostician/Professional: _____

Signature: _____ Date: _____

License number/organization: _____

Please submit to:

1601 East Market Street, Murphy Hall, Ste. 01-Lower Level, Greensboro, NC 27411

Main Number: 336-334-7765 Fax: 336-334-7333

Email: accessibilityresources@ncat.edu