



# PimaCommunityCollege

## Evaluation Questionnaire for Physician/Health Care Provider re Academic Progress

If you have any questions, please call 206-4950.

Name of Student \_\_\_\_\_ Date \_\_\_\_\_

Student's Address \_\_\_\_\_

Semester(s) Under Review \_\_\_\_\_ PCC ID# \_\_\_\_\_

### To be filled out by the Physician or Health Care Provider:

Please describe whether the student or the student's immediate family member suffered an injury, illness or disability that in your opinion would impact the student's ability to succeed academically during the semester(s) under review. Please give details, including any diagnosis, prognosis and. If applicable, the amount of time that the student was unable to attend school during the semester(s) under review

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Has there been any change in the condition of the student or student's immediate family member since the semester(s) under review? Please explain any changes.

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Please make any additional comments that you feel are pertinent to this situation on the back of this form.

Physician/Health Care Provider Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

Telephone Number \_\_\_\_\_