GROSSMONT COLLEGE NURSING PROGRAM

DISABILITY CERTIFICATION FORM

The following form is provided to the applicant in order to verify a documented disability for the purpose of awarding points toward their application (1 point). Specific diagnosis should not be disclosed. The form should be completed by the applicant's care provider.

NAME: ____

Last First

Disability Certification	
Provider Name:	
Provider Address:	
Provider Contact Info:	
By providing my signature below, I certify that the above-named patient has a documented disability.	
Provider Signature:	Date:

Grossmont Nursing promotes equity in our admission practices but does not require applicants to disclose their individual disability.