EAST GEORGIA STATE COLLEGE
COVID-19 Alternative Educational Arrangement Request Form

STUDENT INFORMATION					
Student Name:		EGSC ID #			
Home Phone #:		Cell Phone #:		E-mail:	
Student Status: Current _____ or Transfer ______ (choose one) Location: _____ Swainsboro _______ Statesboro ________ Augusta					

VOLUNTARY DISCLOSURE OF HEIGHTENED RISK:

What CDC underlying medical condition do you have indicating you are or might be at an increased risk for severe illness from COVID-19?

REQUESTED ALTERNATIVE EDUCATIONAL ARRANGEMENTS:

What specific alternative educational arrangement are you requesting? Please select from the options below or identify the arrangement requested in the space provided.

☐ Modification of in-person component of course (ex. online, lecture capture, synchronous/ asynchronous)

☐ Peer notetaker

☐ Modified arrival/departure times for classes

☐ Course substitutions (with permission of the appropriate academic department)

☐ Preferential seating

☐ Rental of hearing amplification device

☐ Other: ____

Approved Alternative Educational Arrangements will end as follows: Temporary conditions (pregnancy, obesity, etc.) will end upon resolution of the temporary conditions. Permanent Conditions will end no later than the end of the public health emergency as determined by the CDC.

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SUPPORTING MEDICAL DOCUMENTATION

Supporting medical documentation is required to be considered for Alternative Education Arrangements. Please attach supporting medical documentation of the CDC recognized underlying health condition and describe the health condition.

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PHYSICIAN CONTACT INFORMATION: Your physician may receive communication from EGSC Counseling and Disabilities Services requesting information about your CDC recognized circumstance/underlying health condition and recommendations for alternative educational arrangements.

Physician's Name:		Physician's Email Address:	
Physician's Telephone #:		Physician's Address:	

STUDENT AUTHORIZATION

I authorize a representative of the EGSC Counseling and Disabilities Office to communicate directly with my health care provider for confirmation of the CDC underlying health condition and clarification regarding my need for an alternative educational arrangement.

Student Signature | Date

STUDENT CERTIFICATION

I certify that the above information is accurate and complete. I understand that I must contact EGSC Counseling and Disabilities Office regarding any changes or deviations to this request once submitted.

Student Signature | Date

EGSC USE ONLY

All required documentation received from student: No __ Yes ___ Received on date: ___________

Documentation confirms CDC underlying health condition: No __ Yes ___

Alternative Educational Arrangement ___ Approved ___Denied

If approved, describe alternative educational arrangement:

____ _____________________

Director of Counseling and Disabilities Date

7-22-2020