Associate Deanship for Student Affairs
Student Programs Coordination Office
Accessibility Services Program

Reasonable Accommodations Request Form

Reference # ___________________________

A. To be completed by student

Date: ________________________________ Academic Year: _________________________

Semester: Fall ________________ Spring ________________ Summer _______________

Name: ___________________________________ Date of Birth: _______________________

Permanent Address: ____

City: ___________________________________ State: __________ Zip Code: ___________

E-mail: ____ Phone: _______________________

Program: MD _____ MPH _____ BSN _____

Level: I _____ II _____ III _____ IV _____

Contact Person: ____

Relation: ____ Phone: _____________________

Type of Difficulty: ____

____

Type of Accommodation Requested (please describe): ____________________________

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____

Have you received accommodations specific to your disability in the past?

Yes _____ No _____ If yes, describe: ____

I authorize my health care provider(s) ____ to release the following information from my patient file to the Student Programs Director for the purpose of determining appropriate accommodations to my disability.

Student signature ______________________________ Date _____________________

B. To be completed by health practitioner

Diagnosis of Disability (Please include the date of diagnosis and describe the diagnostic criteria/test used.)

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Will the disability result in a long term (6+ months) or permanent condition?

Yes _____ No _____

Is the student taking medications or treatments that would be expected to affect performance? Yes _____ No _____

If yes, please explain: ____

____

Would these pose a direct threat or safety risk? Yes _____ No _____

If yes, please explain: ____

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Please describe how the disability affects the student's ability to meet the academic requirements. ____

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Are additional limitations anticipated? Explain: ___________________________________

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Accommodations needed: ____

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Health Practitioner Name: ____

Address: ____

Phone: ___________________________________ License #: _____________________

Specialty: ____

Signature: _________________________________ Date: _______________________