

ADA ACCOMMODATION REQUEST

Part A: Student Information

Return to: Meg Whiston, Director of Student Success Services

To request an accommodation under the Americans with Disabilities Act of 1990, please submit Part A and Part B of this form at least three weeks prior to the beginning of the academic term to ensure a greater likelihood any accommodations granted will be in place for the first day of the term. **Accommodations will not be applied retroactively.**

Student Name: _____ Student email: _____
Last First MI

Academic Program: _____

Disability: (Please check all disabilities for which an accommodation is requested)

<input type="checkbox"/> Hearing	<input type="checkbox"/> Autism Spectrum Disorder
<input type="checkbox"/> Vision	<input type="checkbox"/> Mobility
<input type="checkbox"/> Learning Disability (___ Reading ___ Writing)	<input type="checkbox"/> Attention Deficit Disorder
<input type="checkbox"/> Neurological	<input type="checkbox"/> Respiratory
<input type="checkbox"/> Psychological/Psychiatric	<input type="checkbox"/> Other (please describe) _____
<input type="checkbox"/> Wounded Warrior (please specify) _____	_____
<input type="checkbox"/> Speech	_____

Please check all of the adaptive equipment/services you use on a regular basis:

<input type="checkbox"/> Cane	<input type="checkbox"/> Assistive speech device
<input type="checkbox"/> Hand-held recording device	<input type="checkbox"/> SmartPen
<input type="checkbox"/> Magnification equipment	<input type="checkbox"/> Text-to-speech or speech-to-text software
<input type="checkbox"/> Service animal	(Specify) _____
<input type="checkbox"/> Hand splints	<input type="checkbox"/> Other (please specify) _____
<input type="checkbox"/> Manual or power wheelchair	_____

Have you received accommodations in the past?

Yes No If yes, please submit documents showing previous accommodations.

I understand my ADA file and other university records may be accessed in order to provide me with support services. I understand it is my responsibility to notify the Director of Student Success Services of any change in my disability status or requested accommodations.

Date

Student Signature

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Part B: Licensed Professional Disability Documentation

Student Name: _____ Student email: _____
Last First Mi

To the Diagnosing Professional: Please provide the following medical information. This will be considered when determining reasonable accommodations for the above-named student. Any supporting documentation must be attached to this form and must be **legible (preferably typed), signed, and dated on letterhead.**

Diagnosis/Disability Requiring Accommodation:

Presenting limitations resulting from the above diagnosis with attention to the educational environment:

Duration of Disability (If temporary disability, please note here):

Recommended accommodations or adaptive/assistive services based on the diagnosis:

Please provide signature or official stamp below:

Licensed Professional Printed Name

Title, Licenses, Credentials

Licensed Professional Signature

Date

Official Stamp: _____
Hospital/Clinic/Practice Group Name, Address and Telephone