adler | GRADUATE SCHOOL

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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)

_____ Hearing
_____ Vision
_____ Learning Disability (___ Reading ____ Writing)
_____ Neurological
_____ Psychological/Psychiatric
_____ Wounded Warrior (please specify)
_____
_____ Speech

_____ Autism Spectrum Disorder
_____ Mobility
_____ Attention Deficit Disorder
_____ Respiratory
_____ Other (please describe) _____
_____
_____
_____

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

_____ Cane
_____ Hand-held recording device
_____ Magnification equipment
_____ Service animal
_____ Hand splints
_____ Manual or power wheelchair

_____ Assistive speech device
_____ SmartPen
_____ Text-to-speech or speech-to-text software
(Specify) _____
_____ Other (please specify) _____
_____

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

ADA ACCOMMODATION REQUEST

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:

_____
Date

_____ _____
Licensed Professional Printed Name Title, Licenses, Credentials

_____
Licensed Professional Signature

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