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  _________ Autism Spectrum Disorder
_______ Vision  _________ Mobility
_______ Learning Disability (___ Reading    ___ Writing)  _________ Attention Deficit Disorder
_______ Neurological  _________ Respiratory
_______ Psychological/Psychiatric  _________ Other (please describe) __________
_______ Wounded Warrior (please specify)  __________________________________________
_______ Speech  __________________________________________

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

_______ Cane  _________ Assistive speech device
_______ Hand-held recording device  _________ SmartPen
_______ Magnification equipment  _________ Text-to-speech or speech-to-text software
_______ Service animal  (Specify) __________________________
_______ Hand splints  _________ Other (please specify) __________________________
_______ 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
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