

STUDENT ACCESSIBILITY SERVICES REQUEST FOR STUDENTS (Page 1 to be completed by student)

The U.S. Department of Education has defined a disabled person as a “person who has a physical or mental impairment which substantially limits one or more life activities, has a record of such impairments or is regarded as having such an impairment.” (Federal Register Part IV, 4 May 1977). Examples of disability include, but are not limited to, eyesight, hearing, or mobility impairments; epilepsy; chronic disease; dyslexia and other learning disabilities.

NEOMED is committed to providing reasonable support and accommodations for qualified disabled students who are admitted. At the same time, the University must ensure all students meet certain essential functions; specific functions defined as “essential” are outlined in the Student Handbook by each college. You are encouraged to inform the University if you have a disability that requires accommodation now or possibly in the future.

Please return this form if you have a disability or require accommodations. Any information you provide is strictly voluntary and will be shared only with the members of the Disabilities and Accommodations Committee.

NAME _____

Phone _____

College and Class:

- Medicine: Class of _____
- Pharmacy: Class of _____
- Graduate Studies

Check all that apply:

- I am Registering a Disability
- I am Requesting Accommodations (documentation required, see attached form)
- I am Requesting a Change in Accommodations (please describe below)
 - Due to changing environmental/educational conditions
 - Due to significant changes in the disability (new documentation required)
- I am Requesting a Continuation of my Accommodations (Updated documentation will be required every two years at a minimum. The Disabilities and Accommodations Committee may require updated information from your treating provider more frequently based on the diagnosis and/or accommodation.)

Diagnosis requiring accommodation: _____

Description of impact of disability on educational functioning: _____

Description of stability/variability of symptoms requiring accommodations: _____

History of approved educational accommodations: _____

I agree to allow NEOMED to release the nature of my disability on a need to know basis only, including to faculty or staff responsible for providing the accommodations.

Signature _____ Date _____

DOCUMENTATION FORM

ACCOMMODATION REQUEST (Pages 2-4 to be completed by treating professional)

Student Affairs provides academic accommodations to students with disabilities that reflect a current substantial limitation to a major life activity. To ensure the provision of reasonable and appropriate accommodations for our students, this office requires current and comprehensive documentation of the disorder from a current treatment/assessment professional who is legally qualified to make the diagnosis. All documentation is reviewed on a case-by-case basis.

Name of Student: _____ **DOB:** _____

Date of Diagnosis _____

1. Please describe the diagnosis, symptoms for this diagnosis, severity of impairment, duration and expected long-term impact.

2. Please describe what assessment and evaluation procedure or process you used to make this diagnosis.

3. Please list his/her current treatment regimen, including any medications or psychotherapy currently being utilized by the student. If the student is on a medication, please provide the medication(s) name, dosage, frequency and possible adverse side effects as they could relate to academic/professional performance.

4. Please describe how this diagnosis exhibits itself as a current substantial limitation to learning in an academic/professional environment.
5. Please list any recommendations you would have for academic accommodations that would help this student succeed in the graduate/professional environment. These recommendations will be used to help determine the appropriate and reasonable accommodations that will be made available to this student.
6. Please state what, if any, academic accommodations have you recommended for this student in the past for this diagnosis.
7. Please describe any other relevant information that has not been addressed in the information above.

NOTE: Student Affairs will not accept disability-related documentation from treatment professionals who are in any way related by blood, marriage or adoption to the student requesting services. In order to provide the appropriate analysis to documentation received, Student Affairs must be able to rely on treatment professionals with the highest capacity for objectivity.

Signature: _____ Date: _____

Print name and title: _____

Address: _____ Phone: _____

The information that you provide is maintained in Student Affairs according to the guidelines of the Family Educational Rights and Privacy Act (FERPA) and will become part of the student's permanent file at NEOMED.

Please allow 2 weeks from the submission of the request form for the review approval process.

Please return this form to:

**Northeast Ohio Medical University
Office of Student Affairs
4209 State Route 44
PO Box 95
Rootstown, OH 44272-0095
330-325-6735; FAX 330-325-5905**