

Accommodations Request Form

Name of Applicable Program _____

Name _____

Address _____

Primary Phone Number _____

Primary Email Address _____

Disability Information:

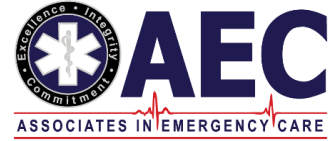
Please identify your disability diagnosis and include details regarding the nature, severity, duration of impairment and any activities or functions that are limited by the disability, along with the extent to which the disability may affect the ability to perform the functions needed to successfully complete the program.

Accommodations Requested:

Please describe the accommodations you are requesting. If there is more than one accommodation that you believe will meet your needs, please describe all possible accommodations. Be specific and thorough, as any additional requests will need to be processed and may delay any accommodation considerations.

Duration of the Requested Accommodation(s).

Please state the length of time the requested accommodation(s) will be needed.



Associates in Emergency Care

How the Accommodation(s) will Enable you to Perform the Program Requirements

Please explain how the requested accommodation(s) will enable you to perform the Program Requirements.

Additional Information

To the extent not provided in response to any of the forgoing requests for information, please provide any additional information you feel may be relevant to your request.

Required Attachments

Documentation from an appropriate health care or rehabilitation professional is required to consider this application. This includes psychiatrists, psychologists, nurses, physical therapists, occupational therapists, vocational rehabilitation specialists in addition to medical doctors. Any Individual Education Plans (IEPs), current or previous, should also be attached.

Attachments Included:	<input type="checkbox"/> Documentation from healthcare/rehabilitation professional <input type="checkbox"/> IEP <input type="checkbox"/> Other
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Reviewed By <input type="checkbox"/> Accommodations Coordinator	Date
Signature:	
<input type="checkbox"/> Executive Team	Date
Signatures:	
Attachments Reviewed:	<input type="checkbox"/> Documentation from healthcare/rehabilitation professional <input type="checkbox"/> IEP <input type="checkbox"/> Other
Is the Documentation sufficient?	<input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain)
Decision on Accommodations	Approved (Please list accommodations that will be provided)
	Denied (Please provide explanation)