LOGAN UNIVERSITY

# Accommodation Request Form

The purpose of this form is to assist the University in determining whether, or to what extent a reasonable disability/pregnancy accommodation is required. Questions related to the completion of this form or requests for assistance should be addressed to the Disability Services Coordinator in Room 147, (636) 230-1732.

The Health Care Provider Assessment portion of this form is to be completed by a medical professional with primary oversight of the qualifying diagnosis or another qualified health care provider. To ensure timely and effective provision of services, accommodations should be requested at least one month in advance. However, requests may be made at any time, and efforts will be made to accommodate eligible requests as soon as possible.

**This form is for voluntary disclosure of a disability/pregnancy only**. You are not required to complete it unless you are requesting accommodations for a disability/pregnancy.

Eligibility for support services for students requesting accommodations depends upon evaluation of the following requirements by the University:

1) Student has been recently assessed within 3 years of the trimester for which the student requests accommodations and is determined to have a functional limitation in the educational setting;

2) Student provides verification of diagnosis of disability/pregnancy; and

3) Diagnosing professional provides specific recommendations for accommodations to aid student in the educational setting.

Name: _____

Address: _____ City, State: _____ Zip: _____

Phone: _____

Briefly describe the nature of your accommodation request: _____

_____

_____

Have you previously received academic accommodations in school? Yes: _____ No: _____ If yes, please explain:

_____

_____

_____

Date of your most recent psychoeducational or medical evaluation: _____

**Note:** This application cannot be processed until pertinent documentation of a disability/pregnancy has been provided. To ensure the provision of reasonable and appropriate accommodations, students requesting these services must provide comprehensive documentation of their disability/pregnancy.

Has a physician, vocational rehabilitation specialist or other qualified health professional recommended a specific accommodation? If so, please describe the service(s) received, the name of the health provider and his/her phone number.

Specific accommodation: _____

_____

Health provider: _____

Phone: _____

By my signature below, I authorize the release of all relevant information, records and documentation to Logan University for the purpose of determining my eligibility for disability/pregnancy accommodations related to my enrollment or participation in courses, programs, or activities offered by the University. I understand that select administrators and faculty with a need-to-know as determined by the University will have access to review copies of all documentation provided.

Student Signature: _____ Date: _____

Print Name: _____

**The following pages are to be completed by the doctor or other medical professional that diagnosed the condition.**

## Health Care Provider Assessment

Please provide the following information for the student (attach additional sheets if needed):

**I. Diagnosis and Date**: _____

_____

_____

Level of severity and longevity: _____

**II. Testing**: Procedures, measures, and observations used to make the diagnosis.
(**Please include copies and scores of all diagnostic test batteries if applicable)**

_____

_____

_____

_____

_____

Was medication prescribed for a disability? Yes: _____ No: _____ If yes, what? _____

_____

Amount and frequency of administration: _____

Response to medication: _____

_____

_____

**III. Assessment**: Describe the student's functional limitations in a post-secondary educational setting:

_____

_____

_____

_____

**IV. Recommended Accommodations and Rationale:** What recommendations do you make regarding effective accommodations to equalize this student's educational opportunities at the post-secondary level? (Describe the services and accommodations in exam administration, classroom or student activities or adjustment of classroom physical environment):

Please include and attach any information you have on learning disability testing, intellectual functioning, and/or academic problems, which you feel we should know in order to assist the student:

Thank you for your prompt assistance in providing this information. Please return this form to:

Disability Services Coordinator
Student Services
Logan University
1851 Schoettler Rd.
Chesterfield, MO 63017
Fax - 636-207-2407

Providers' Name and Credentials: _____

Address: _____ City, State: _____ Zip: _____

Phone: _____

Signature: _____ Date: _____