



Disability Notification and Accommodation Request Form

The purpose of this form is to assist the College in determining whether, or to what extent a reasonable disability 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 part of this form is to be completed by a qualified health care provider or other qualified professional. To insure 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 only.** You are not required to complete it unless you are requesting accommodations for a disability.

Eligibility for support services for students with disabilities depends upon evaluation of the following requirements by the College:

- 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;
- Student provides verification of diagnosis, longevity, and severity of disability; and
- Diagnosing professional provides specific recommendations for accommodations to aid student in the educational process.

Name: _____

Address: _____ Phone #: _____

Briefly describe the nature of your disability. _____

Did you previously have academic accommodations in school? _____ 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 has been provided. To ensure the provision of reasonable and appropriate accommodations, students requesting these services must provide comprehensive documentation of their disability to satisfy the eligibility requirements listed above. Appropriate services will be determined from the specific information provided. The College may arrange for an additional independent evaluation as it may deem necessary.

What accommodations do you feel that you need in order to pursue your education at Logan?

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

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

Student Signature

Date

Student's Printed 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 as needed):

Diagnosis and date: _____

Level of severity and longevity: _____

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

Was medication prescribed for a disability? _____ If yes, what? _____

Amount and frequency of administration: _____

Response to medication: _____

Assessment: Describe the student's functional limitations in an educational setting:

Recommended Accommodations & 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 study 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 help the student.

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

Disability Services Coordinator
Student Services
Logan College of Chiropractic
1851 Schoettler Rd.
Chesterfield, MO 63017

Provider's Name and Credentials: _____

Address: _____ Phone Number: (____) _____

Signature

Date