THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER

Office of Academic Support
2500 North State Street
Jackson, Mississippi 39216-4505
T: (601) 815-4233
F: (601) 815-5828

REQUEST FOR ACADEMIC ACCOMMODATIONS

Please fax/mail the completed application with signatures of student and healthcare provider to:
Office of Academic Support
UMMC Academic Affairs, U155-A
University of Mississippi Medical Center
2500 North State Street
Jackson, MS 39216
Fax: 601-815-5828

COMPLETED BY STUDENT:

Date:	**Student's Full Name:**
UMMC ID #:	**Date of Birth:**
Phone Number:	**Email Address:**
Address:	**Program:**
School: (circle one) **Dentistry** **Graduate Studies** **Health Related Professions** **Medicine** **Nursing**	

Please list the disability for you which you are requesting academic accommodations:_____
_____

What is the impact of the diagnosed disability on your functioning in the classroom and other academic environments:_____
_____
_____
_____

Have you received accommodations in the past? ☐Yes ☐No
If yes, list the type of prior accommodations received and indicate whether it was helpful:

Prior Academic Accommodation	Effectiveness
1.	☐Helpful ☐Not Helpful
2.	☐Helpful ☐Not Helpful
3.	☐Helpful ☐Not Helpful
4.	☐Helpful ☐Not Helpful

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Release of Information

It may be necessary to contact a student's health care provider during the verification process.

Please indicate the healthcare provider who will complete this form and may be contacted on your behalf:_____

By signing below, I am acknowledging that I am allowing the Office of Academic Support to contact those listed above. **I understand that this permission extends to the verification process only**.

_____ _____

Signature of Student Date

Disclosure Information

By completing and signing this intake application, the signer is voluntarily disclosing a disorder and requesting accommodations. Disclosure of a disorder at this time does not necessarily confirm eligibility status for services or accommodations. While the Office of Academic Support will make every attempt to quickly review all requests for accommodations, the verification process may take several weeks or longer, depending upon the comprehensiveness and currency of the documentation submitted.

All information submitted to this office is to be completely confidential and used only for the purposes of verification and in connection with this institution's commitment and obligation to students with disabilities.

By signing below, I confirm that I have read (or have had read to me) and understand this document.

_____ _____

Signature of Student Date

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COMPLETED BY HEALTHCARE PROVIDER:

INSTRUCTIONS: All providers must complete sections A, B, and C below. Application can only be considered if information provided is legible and complete. Evaluation must have occurred within the past 3 years.

Section A

Healthcare Provider's Name:	**Title:**
Specialty:	**License/Certification Number:**
State Licensed/Certified to Practice:	**License/Certification Expiration:**
Name of Office/Affiliation:	**Telephone:**
Fax:	**Email Address:**
Office Address:	

Section B

Are you a family member of this student? ☐Yes ☐No

Diagnosis (Include ICD/DSM Code):_____

_____

_____

_____

_____

_____

Date of Most Recent Evaluation of Student:_____

Date of Initial Evaluation of Student:_____

Please describe the clinical criteria on which this diagnosis is based:_____

_____

_____

_____

_____

_____

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The University of Mississippi Medical Center supports both the letter and the spirit of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. As such, the documentation requirements are holistic in nature and value the unique experiences and history of each individual student. Accommodations are provided based on the impact of the disability, not only the diagnosis of a disability. Provide a detailed narrative that describes the impact of the diagnosed disability on the student's functioning in the classroom and other academic environments:_____

_____
_____
_____
_____
_____

The assessment and documentation should clearly exhibit the fidelity and integrity necessary to support the request for accommodations. Please note that self-report surveys can supplement the diagnostic profile but are not considered adequate in themselves for diagnoses.
List the assessment tools used in the evaluation and diagnosis (include psychological/neuropsychological/cognitive tests for learning and psychiatric disorders, and/or include the diagnostic procedures used to diagnose physical conditions):_____

_____
_____
_____
_____
_____

List current medications, if applicable, and what impact medications may have on the student's functioning:_____

_____
_____
_____
_____
_____

Provide a description of the expected prognosis or progress of the diagnosed disability (i.e., stability, fluctuations, etc.):_____

_____
_____
_____
_____
_____

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Accommodations are approved on a case-by-case basis depending on the impact of the student's disability and the reasonableness of the request. Reasonable accommodations are determined using the following analysis.

- The accommodation is directly related to the impact or functional limitations caused by the diagnosed disability.
- The accommodation is necessary to provide equal access to the student.
- The accommodation does not fundamentally alter the essential elements of the course, program, or activity.

Please recommend specific accommodations that link the recommended accommodation(s) to the specific functional limitations of the student:_____

_____

_____

_____

_____

_____

Provide a clear connection between the recommendation(s) and the impact of the diagnosed disability:_____

_____

_____

_____

_____

_____

Section C

Is this application for academic accommodations based on a Attention-Deficit/Hyperactivity Disorder or a learning disorder or other cognitive impairment? ☐Yes ☐No

If yes, please attach the psychoeducational or neuropsychological assessment that includes, but is not limited to, description of presenting symptoms; developmental history; relevant academic history; relevant psychosocial history; relevant medical history; comprehensive battery of objective tests beyond self-report; discussion of differential diagnosis; and documentation of specific diagnosis. (Note: self-report surveys can supplement the diagnostic profile but are not considered adequate in themselves for diagnoses.)

_____ _____

Signature of Healthcare Provider Date