

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.	<input type="checkbox"/> Helpful <input type="checkbox"/> Not Helpful
2.	<input type="checkbox"/> Helpful <input type="checkbox"/> Not Helpful
3.	<input type="checkbox"/> Helpful <input type="checkbox"/> Not Helpful
4.	<input type="checkbox"/> Helpful <input type="checkbox"/> Not Helpful

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

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: _____



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.): _____

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 Attention-Deficit/Hyperactivity Disorder or a learning disorder or other cognitive impairment?

Yes No

If yes, please complete page 6 of this application and attach the psychoeducational or neuropsychological assessment completed by a licensed provider qualified to perform this type of assessment and diagnosis. The psychoeducational or neuropsychological assessment includes, but is not limited to, a 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.)

A psychoeducational or neuropsychological assessment is attached.

If attached, please complete the information below for the licensed provider who completed the psychoeducational or neuropsychological assessment and diagnosis.

Evaluator'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:	

Signature of Healthcare Provider	Date