

## ACCOMMODATION REQUEST FORM

In order to receive accommodations, please submit a copy of this form along with the Disability Verification Form with															
accompanying documents to the designated Campus Official. Student's Name:							Dat	Date of Birth:							
Addres	ς.														
	-						- 1								
E-Mail:								Phone Number:							
Campus:								Program & Cohort:							
What is the nature of your impairment?															
Learning 🗆 Visu							sual			Oth	er 🗆				
							ironic I	Health							
Hearing D Me						ental F	lealth								
Please	list the a	accomm	nodatio	ns or se	rvices that you are cur	rently	y reque	esting:							
Accom	modatic	on:					F	lave you	u used t	his bef	ore?	YES 🗆	NO		
Accom	modatic	on:					H	lave you	u used t	his bef	ore?	YES 🗆	NO		
Accommodation:								lave you	u used t	his bef	ore?	YES 🗆	NO		
Accom	modatic	on:					⊦	lave you	u used t	his bef	ore?	YES 🗆	NO		
Accom	Accommodation: Have you used this before? YES D NO D														
What o	ther tre	atment	s are b	eing adr	ninistered?										
lf you h	ave rec	eived a	ccomm	odation	s at a previous institut	ion, p	lease	describe	e the ac	commo	odation	and how it	has helpe	ed you:	
					·								·		
	anvthi	ng else '	vou thi	nk we sł	nould know about your	r med	lical co	ndition	·						
15 there	. anytim	ig cisc	you thi	int we si		mea		nancion	•						
Please check which areas listed below you believe are affected as a result of your medical diagnosis and/or medication. Please indicate the level of limitation you experience as a result of your disability.															
1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact															
1	2	3	4	5	Major Life Activities		1	2	3	4	5	Learning	/ Time Mar	nagement	
					Caring for Oneself	] [						Memory			
					Talking							Concentra	ating		
					Hearing	┤┝						Listening			
					Breathing	┤┝						Organizat			
					Seeing	┥┝							distraction of		
	L				Walking							mely sul	0110300110		



## ACCOMMODATION REQUEST FORM

						assignments
		Standing				Attending class regularly
		Lifting/Carrying				Making and keeping appointments
		Sitting				Managing stress
		Performing Manual tasks				Reading
		Eating				Writing
		Working				Spelling
		Interacting with others				Quantitative reasoning (math)
		Sleeping				Processing Speed

## Authorization to Release Medical Information & Confidentiality

I have requested accommodations from Gurnick Academy of Medical Arts under The Americans with Disabilities Act (ADA) of 1990. I hereby authorize the ADA Coordinator for Gurnick Academy to communicate directly with the health care provider who completes the Disability Verification Form in order to obtain clarification of issues relating to the functional limitations for which I am seeking accommodation.

All medical related information shall be kept confidential to protect the privacy of the student. However, during the process of determining and providing accommodations, other individuals required in making connections for accommodations may be advised of necessary information. First aid and safety personnel may be informed, when appropriate, if the disability might require emergency treatment or if any specific procedures are needed in the case of fire or other evacuations. Government officials investigating compliance with the ADA may also be provided relevant information as requested.

The authorization will automatically end upon completion of the program listed on the Enrollment Agreement.

Student Signature: \_\_\_\_\_

\_ Date: \_\_

SCHOOL OFFICIAL USE ONLY:								
Date Accommodation Form Submitted:								
Date Disability Verification Form Submitted:								
Accommodation Request: Approved Denie								
Signature of School Official:	Date:							
Ч <u></u>								