Request for Disability Accommodation

PART I: TO BE COMPLETED BY THE STUDENT

I hereby authorize _____ to release information regarding my disability and accommodation needs to the University of Scranton.

Name: _____
LAST NAME , FIRST NAME MIDDLE NAME

Date of Birth _____ Class Year _____

Dates of Requested Accommodation _____ to _____
START END

1. How would this disability affect your performance in the classroom, and what accommodations would be helpful?

PART II: TO BE COMPLETED BY THE MEDICAL PROVIDER

The student listed above has requested accommodations for the classroom. Please provide information regarding the student's disability and recommended accommodations.

Please note the following:

- Although the student may request accommodations, you are the professional who will determine what is reasonable and appropriate.
- The student is responsible for providing you with the Request for Disability Accommodation form. If you have any questions regarding the student's request, please contact the Office of Disability Services.

1a. What diagnostic criteria/tests were used to establish the diagnosis?

- DSM-IV
- Other: _____

2. What is the student's prognosis (e.g., is the disability permanent, chronic, episodic)?

3a. Date of birth _____

3. Do you have any other name or initial that you usually use?

4. If the last name changed, what was your last name when you were born?

5. Are you a male who is required to register with the Selective Service? If "Yes," go to Section 6. If "No," what is the reason this does not apply to you?

6. Are you presently employed? If yes, please provide the following:

Address