REQUEST FOR ACADEMIC ACCOMMODATIONS

Please email, fax, or mail to:

Student Success
Office of Student Affairs
University of Mississippi Medical Center
Norman C. Nelson Student Union
2500 North State Street
Jackson, MS 39216
Phone: 601-815-5064
Fax: 601-815-5828
StudentSuccess@umc.edu

COMPLETED BY STUDENT:

Date:	Student's Full Name:
Date of Birth:	UMMC Student ID:
Phone Number:	UMMC Email Address:
Address:	Program:

School:	Dentistry	Graduate Studies	Health Related Professions
	Medicine	Nursing	Population Health

List the disability for which you are requesting academic accommodations:___________________

____

Describe the impact of the diagnosed disability on your functioning in the classroom and other academic environments:____

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Have you received accommodations in the past? Yes No

If yes, list the prior accommodations received and indicate whether they were helpful:

Prior Academic Accommodation	Helpfulness
1.	Helpful Not Helpful
2.	Helpful Not Helpful
3.	Helpful Not Helpful
4.	Helpful Not Helpful

Release of Information

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

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

By signing below, I am allowing Student Success in the Office of Student Affairs to contact the healthcare provider listed above. I understand that this permission extends to the verification process only.

____ ____________________

Signature of Student Date

Disclosure Information

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

All information submitted to Student Success in the Office of Student Affairs is 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 am confirming that I have read (or have had read to me) and understand the disclosure information above.

____ ____________________

Signature of Student Date

UMMC™
Office of Student Affairs

COMPLETED BY HEALTHCARE PROVIDER:

INSTRUCTIONS: All healthcare providers must complete sections A, B, and C below. The request can only be considered if the information provided is legible and complete. The most recent 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):______________________________

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____

Date of Your Most Recent Evaluation of Student:______________________________

Date of Your Initial Evaluation of Student:______________________________

Describe the clinical criteria on which this diagnosis is based:______________________________

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List the assessment tools used in the evaluation and diagnosis (include psychological, neuropsychological, and/or cognitive tests for learning and psychiatric disorders, and/or include the diagnostic procedures used to diagnose physical conditions). Please note that self-report surveys can supplement the diagnostic profile but are not considered adequate in themselves for diagnoses:____

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

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

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 Updated: 08/2023

Academic accommodations are provided based on the impact of the disability, not only the diagnosis of a disability. Academic 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 academic accommodations are determined using the following analysis.

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

Describe the impact of the diagnosed disability on the student's academic functioning:	**Recommend specific academic accommodations:**

 Updated: 08/2023

Section C

Is this request for academic accommodations based on Attention-Deficit/Hyperactivity Disorder, learning disorder, or other neurodevelopmental or neurocognitive disorder?

Yes No

If yes, please attach the psychoeducational or neuropsychological assessment completed by a licensed provider qualified to perform this type of assessment and diagnosis and list that licensed evaluator's information below. The psychoeducational or neuropsychological assessment must have occurred after the student was age 18 and 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; interpretation of test results; 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 and the licensed evaluator who completed the psychoeducational or neuropsychological assessment and diagnosis is as follows:

Licensed Evaluator's Name:	**Specialty:**
Name of Office/Affiliation:	**Telephone:**
Fax:	**Email Address:**
Office Address:	

____
Printed Name of Healthcare Provider

______________________________ ______________
Signature of Healthcare Provider Date