



Office of Academic Support
The University of Mississippi Medical Center

REQUEST FOR ACADEMIC ACCOMMODATIONS

Please email, fax, or mail to:
Office of Academic Support, U155-A
University of Mississippi Medical Center
2500 North State Street
Jackson, MS 39216
Phone: 601-815-5064
Fax: 601-815-5828
AcademicSupport@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 Medicine	Graduate Studies Nursing	Health Related Professions 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: _____

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



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

By signing below, I am allowing the Office of Academic Support 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 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 completeness, comprehensiveness, and currency of the documentation submitted.

All information submitted to the Office of Academic Support 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



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): _____

Date of Your Most Recent Evaluation of Student: _____

Date of Your Initial Evaluation of Student: _____



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

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: _____

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): _____



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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:



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 provider’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 provider who completed the psychoeducational or neuropsychological assessment and diagnosis is as follows:

Licensed Provider’s Name:	Specialty:
Name of Office/Affiliation:	Telephone:
Fax:	Email Address:
Office Address:	

Printed Name of Healthcare Provider

Signature of Healthcare Provider

Date