



Office of Disability and Access

226A Warner Library 610-341-5990 (P) 610-341-1705 (F) oda@eastern.edu (E)

REQUEST FOR ACCOMMODATIONS FOR STUDENTS WITH DISABILITIES

Academic/Other (Student Form)

Procedure for requesting accommodations for **academics** through the Office of Disability and Access (ODA):

1. Review the *Accommodations for Students with Disabilities Policy* at www.eastern.edu/oda
2. Student fills out the *Request for Accommodation for Students with Disabilities* form (**this form**)
3. Provide documentation from a healthcare provider able to diagnose and treat the disabling condition
4. Submit request form, documentation and release form to the Director of the Office of Disability and Access (ODA) by email (oda@eastern.edu) or fax: 610-341-1705
5. Schedule accommodation intake meeting with ODA staff by emailing oda@eastern.edu

Note: Submitting the request form and relevant documentation is the first step in the request process and does not guarantee that accommodations will be approved. If you have questions or need physical assistance to complete the form, please email ODA.

Student Name: _____ Date of Request: _____

EU ID #: _____ Date of Birth: _____

Residence Hall or Home address (if not a residential student): _____

Student Phone #: _____ Eastern email: _____

I. I am requesting accommodations for (check one):

Academics

Other - Check this box for accommodation requests that **do not fit** into any of the other disability policy/procedures through the ODA.

- Requests for accommodations for any of the categories listed below should contact oda@eastern.edu for that request form/policy.
 - Meal Plan
 - Housing
 - ESA/Service Animal
 - Mobility/Parking

II. Program enrolled in at Eastern:

1. Traditional Undergraduate Baccalaureate Program
Year: *First-year* *Sophomore* *Junior* *Senior*
 Transfer (from _____)
Did you have accommodations at the above named institution? *Yes* *No*
2. Non-Traditional Undergraduate (specify program _____)
3. Graduate/Doctoral (specify program _____)
4. Esperanza College
5. Palmer Seminary

III. List all conditions for which you are requesting academic accommodations.

Documented Disability	Name & Title of Professional Who Evaluated Disability	Date of Evaluation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

IV. Provide documentation of disability:

- Healthcare providers should complete the “Healthcare Provider Documentation for Academic/Other Accommodations” form
- Do not give ODA your only copy of your documentation. Make a copy for your records before submitting it to ODA.



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Healthcare Provider Documentation for Academic/Other Accommodations

Eastern University students requesting accommodations for academics or for a reason that does not fit in another category* should have a qualified healthcare provider (ie. professional certified to diagnose the condition and determine that it is disabling) complete this form.

*Separate policies/procedures are available for: Meal Plan, Housing, Mobility/Parking, and/or Emotional Support Animal/Service Animal accommodations.

The healthcare provider may submit their own documentation/evaluation on their letterhead, although it must contain the information requested on page 2.

The student should submit the following forms to the Office of Disability and Access by fax: 610-341-1705 or email - oda@eastern.edu

1. Healthcare Provider Documentation (this form)
2. Request for Accommodations for Students with Disabilities: Academic/Other Accommodations
3. Authorization for Release of Information

Student Authorization to Release Information:

I am requesting accommodations that will affect my academics/mobility at Eastern University. I require supporting documentation from a qualified provider to support this need. I authorize _____ [name of provider] to release the information requested on this form regarding my disability to Eastern's Office of Disability and Access.

Student Name: _____ Date of Birth: _____

Student Signature: _____ Date: _____

-----*This section is to be completed by the student's healthcare provider.*-----

Note: Short, general statements and/or documentation provided on a prescription pad are not acceptable.

Name of healthcare provider: _____

Specialty: _____

Phone: _____ Fax: _____

Address: _____

License/certification number and state of license: _____

Name of Eastern University student requesting accommodations:

Is the above named student currently under your care? (circle): Yes No

Date of last contact with student: _____

How long has this student been in treatment with you? _____

The healthcare provider must answer the questions on pages 3-5, either on this form or on the provider's letterhead. Documentation could also be a copy of the student's evaluation for the disability by their provider (ie. psycho-educational testing, neuropsychological evaluation, medical or psychiatric evaluation, evaluation/reevaluation report for an IEP/504) as long as it includes the information below.

Note: IEPs and 504 plans are created for students in Kindergarten-12th grade and are not automatically approved at the college level.

- A. What is the current diagnosis? A clear statement of diagnosis must be included. A clinical diagnosis in itself is not evidence of disability, however.
- B. How diagnosis was determined (i.e., a psycho-educational testing battery for learning disabilities and ADHD, a neuropsychological evaluation for head injury, a medical or psychiatric evaluation for other medical or psychiatric conditions, etc.)
- C. History of illness/condition (including how/when condition was first diagnosed and by whom, course of illness/condition over time)
- D. Current symptoms (including specific nature of symptoms, frequency, severity)
- E. Extent of functional impairment caused by symptoms/condition (specifically related to life realms for which patient is requesting accommodations, if possible to determine)
- F. What accommodations are needed at the present time (including specific recommendations when possible)
- G. Projected time period for which accommodations might be needed

Healthcare Provider Documentation for (student name) _____

1. What is the current diagnosis? A clear statement of diagnosis must be included. A clinical diagnosis in itself is not evidence of disability, however.

2. How diagnosis was determined (i.e, a psycho-educational testing battery for learning disabilities and ADHD, a neuropsychological evaluation for head injury, a medical or psychiatric evaluation for other medical or psychiatric conditions, etc.)

Healthcare Provider Documentation for (student name) _____

3. History of illness/condition (including how/when condition was first diagnosed and by whom, course of illness/condition over time)

4. Current symptoms (including specific nature of symptoms, frequency, severity)

5. Extent of functional impairment caused by symptoms/condition (specifically related to life realms for which patient is requesting accommodations, if possible to determine)

Healthcare Provider Documentation for (student name) _____

6. What accommodations are needed at the present time (including specific recommendations, when possible)

7. Projected time period for which accommodations might be needed

I certify that the documentation and statements attached are true and accurate:

Healthcare Providers Signature: _____

Date: _____

Please note: Brief notes (i.e., letters on prescription pads) or statements without sufficient supporting information may limit Eastern University's ability to evaluate this request. Forms that lack signature and/or information concerning appropriate provider credentials will not be accepted. Additionally, documentation prepared by parents or relatives of the requesting student is not acceptable.



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Authorization for Release of Information

I authorize ODA to release the following information concerning me:

1. Type of service received: Accommodations due to a disability
2. Date(s) accommodations are approved
3. List of approved accommodations
4. Student name, email and ID#

to the following person(s) or office(s) – check all that apply:

- All current professors
- Academic Advisor
- CAPS (Counseling Office staff)
- College Success Program (CSP) Staff
- Athletics
- Housing office staff
- Resident Director
- Financial Aid
- Student Accounts

other (eg: parent, coach
Healthcare provider)

_____ Name

_____ Relationship to student

Purpose for which information will be used: arrangement & monitoring of accommodations

I understand that I can withdraw or modify this authorization at any time by providing a written request to ODA or, if I am unable to sign a written request, by oral request before two responsible witnesses.

This authorization will expire at the end of this academic year or upon my graduation or exit from the University unless I specify another date here: _____

Student Signature

Date