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**Request for Academic Accommodation**

**What is the Policy and Process?**

Saint Mary’s University provides reasonable accommodations to students with disabilities. Students with diagnosed physical, medical or mental health conditions requiring academic accommodations should complete and return this form, including the section to be completed by your healthcare provider. Diagnostic reports may be submitted as documentation if they address the areas below.

Documentation should be submitted to: **Office of Student Success**

 700 Terrace Heights, #44

 Winona, MN 55987

 Phone: (507) 457-1465

Fax: (507) 457-6660

 khemker@smumn.edu

**To Be Completed by the Student**

Name: Phone:

Email: Current Year:

What is your diagnosed disability?

What major life activities are substantially limited by this disability?

What specific academic accommodation are you requesting? Please explain how this accommodation will address the limitations described above?

**Consent and Release of Information\*:**

* I authorize Saint Mary’s University and its representatives to share information related to my *Request for Academic Accommodations* with relevant departments and individuals. This includes but is not limited to the Office of Student Success, Health and Counseling Services. I recognize that the sharing of this information is necessary for departments to work collaboratively for my benefit.
* I authorize Saint Mary’s University and its representatives to contact my healthcare provider for additional information, related to this request.
* I have read this document thoroughly and agree to the process described.

\*This release is effective from the date signed as long as the student is enrolled at Saint Mary’s University.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Signature Date

**To Be Completed by the Healthcare Provider**

**Instructions for Healthcare Provider Completing this Form:**

The student named above has requested an academic accommodation at Saint Mary’s University of Minnesota.

Saint Mary’s University provides reasonable accommodations to students with documented disabilities. In order to effectively evaluate the student’s request, the University requests documentation from an appropriately qualified provider.

Please answer each question on the form thoroughly, as this information will be used in determining how to most appropriately address the student’s request for accommodations.

Please feel free to contact us with any questions you may have: (507) 457-1465.

**Completed forms can be returned with the student or faxed to:**

Office of Student Success

Fax: (507) 457-6660

**Healthcare Provider Statement for Academic Accommodations**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Major Life Function/Disability Information**

Accommodations are available to students identified as having a disability. The above student has requested accommodations through Access Services. To be considered for those services, Saint Mary’s University requires appropriate documentation. A disability is defined under the Americans with Disabilities Act as “**a physical or mental impairment that substantially limits one or more major life activities**.”

Examples of major life activities include: seeing, hearing, eating, sleeping, walking, standing, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and self-care.

Based on the above definition, does this individual have a disability? **YES NO**

**Health History**

Primary Diagnosis:

Secondary Diagnosis:

(If applicable, attach a copy of evaluation results, pertinent lab work, criteria for diagnosis)

When was this condition diagnosed?

How long has the student been under your care?

Date of your most recent evaluation related to this condition? \_\_\_\_\_\_

Does the student take prescription medication for this condition? **YES NO**

If yes, please specify medications, doses and frequency:

Does the student utilize other treatments or interventions for this condition? **YES NO**

If yes, please describe:

The prognosis for the health condition or disability above is:

Permanent \_\_\_\_\_ 6‐12 months \_\_\_\_\_ 6 months or less \_\_\_\_\_ Episodic (please describe below) \_\_\_\_\_

Will the condition cause episodic flare-ups periodically preventing the student from attending class or completing assignments? **YES NO**

Based upon the patient’s history and your knowledge of their condition, estimate the frequency of flares and related incapacity that the patient may have over the next 12 months (i.e. 1 episode every 3 months lasting 1-2 days):

Frequency: \_\_\_\_\_ times per \_\_\_\_\_ week(s) \_\_\_\_\_ month(s)

Duration: \_\_\_\_\_ hours or \_\_\_\_\_ days(s) per episode

**Additional Information**

What major life activities are substantially limited by this disability (functional limitations)? Please describe:

How would this accommodation impact the student’s function?

**Additional Comments:**

Healthcare Provider Name:

 Please Print Credential or Degree

Signature:

License # / State:

Address:

Phone: Fax:

**Medical Office Stamp:**

**Completed forms and supporting information can be returned with the student or faxed to:**

Office of Student Success

Fax: (507) 457-6660