10225 Yellow Cir Drive
Minnetonka, MN 55343
Phone: (612) 767-7063
Fax: (612) 767-7080
Email:nikki.marchand@alfredadler.edu

ADA ACCOMMODATION REQUEST

Part A: Student Information

Return to: Nikki Marchand, nikki.marchand@alfredadler.edu

To request an accommodation under the Americans with Disabilities Act of 1990, please submit Part A and Part B of this form at least three weeks prior to the beginning of the academic term to ensure a greater likelihood any accommodations granted will be in place for the first day of the term. **Accommodations will not be applied retroactively.**

Student Name:_____ Student email: _____
Last First MI

Academic Program: _____

Disability: (Please check all disabilities for which an accommodation is requested)

_____Hearing
_____Vision
_____Learning Disability (____Reading_____Writing)
_____Neurological
_____Psychological/Psychiatric
_____Wounded Warrior (please specify)
_____
_____Speech

_____Autism Spectrum Disorder
_____Mobility
_____Attention Deficit Disorder
_____Respiratory
_____Other (please describe) _____
_____
_____
_____

Please check all of the adaptive equipment/services you use on a regular basis:

_____Cane
_____Hand-held recording device
_____Magnification equipment
_____Service animal
_____Hand splints
_____Manual or power wheelchair

_____Assistive speech device
_____SmartPen
_____Text-to-speech or speech-to-text software
(Specify) _____
_____Other (please specify) _____
_____

Have you received accommodations in the past?

____Yes_____No If yes, please submit documents showing previous accommodations.

I understand my ADA file and other university records may be accessed in order to provide me with support services. I understand it is my responsibility to notify the Accessibility Resources Coordinator of any change in my disability status or requested accommodations.

_____ _____
Date Student Signature

10225 Yellow Cir Drive
Minnetonka, MN 55343
Phone: (612) 767-7063
Fax: (612) 767-7080
Email:nikki.marchand@alfredadler.edu

ADA ACCOMMODATION REQUEST

Part B: Licensed Professional Disability Documentation

Student Name:_____Student email: _____
Last First Mi

To the Diagnosing Professional: Please provide the following medical information. This will be considered when determining reasonable accommodations for the above-named student. Any supporting documentation must be attached to this form and must be **legible (preferably typed), signed, and dated on letterhead.**

Diagnosis/Disability Requiring Accommodation:

_____
_____
_____
_____
_____

Presenting limitations resulting from the above diagnosis with attention to the educational environment:

_____
_____
_____
_____

Duration of Disability (If temporary disability, please note here):

_____
_____

Recommended accommodations or adaptive/assistive services based on the diagnosis:

_____
_____
_____
_____
_____

Please provide signature or official stamp below:

_____ _____
Licensed Professional Printed Name Date

_____ _____
Licensed Professional Signature Title, Licenses, Credentials

_____
Official Stamp: Hospital/Clinic/Practice Group Name, Address and Telephone