

Temporary Accommodation Request

To request a temporary accommodation under Title III of the Americans with Disabilities Act of 1990, its amendments, and Section 504 of the Rehabilitation Act of 1973, please complete and submit this form.

A temporary disability is a short-term (typically less than 6 months) impairment that is severe enough to substantially limit major life activities (e.g., reading, concentration, walking).

Accommodations cannot be applied retroactively.

Student Name _____
(preferred) Last First MI

Legal Name _____
(if different than preferred) Last First MI

Pronouns ☐ he/him/his ☐ they/them/theirs
☐ she/her/hers ☐ other _____

Student email _____ @mail.alfredadler.edu DOB _____
mm/dd/yyyy

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

Signature

Date mm/dd/yyyy

Please have your healthcare provider complete the section below or attach a detailed note on official letterhead.

- Temporary accommodations will remain in effect for no longer than the current term. If accommodations are still necessary to ensure equal access at the end of the term, the student must request accommodations through the standard ADA Accommodations process. [Accommodations Request Form](#)
- Adler Graduate School utilizes an interactive process to identify disability-related barriers and determine reasonable accommodations. The Accessibility & Career Services Coordinator evaluates essential course and program requirements and selects accommodations that support equal access.
- Adler Graduate School stores disability documentation securely in accordance with the Family Educational Rights and Privacy Act (FERPA). Documentation may be reviewed by the student upon written request.
- If documentation is unclear, you may be requested to provide additional documentation.

Describe the injury/medical condition, degree of impairment, and impact on specific academic tasks (e.g., reading, writing, concentrating):

Expected date of recovery: _____
mm/dd/yyyy

Please provide signature or official stamp below:

Licensed Professional Printed Name

Title, Licenses, Credentials Licensed

Professional Signature

Date

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