



SERVICES FOR STUDENTS WITH DISABILITIES
REQUEST FOR SERVICES FORM

Completion of this form is voluntary. However, UNMC requests that this document be completed for persons seeking accommodation in order to ensure meaningful evaluation and appropriate accommodation consistent with reliable and useful medical information.

GENERAL INFORMATION

Date _____

StudentName _____

Birth date _____ UNMC student ID number _____

Mailing Address _____

Home or Cell Phone _____

City _____ State _____ Zip _____

Wk Phone _____

Campus mail box _____

ADMISSIONS INFORMATION

Enrollment status

_____ Currently enrolled student at UNMC

_____ Accepted for enrollment

_____ Application for admission pending

_____ Other

Semester for which student is initially seeking services

_____ Fall _____ Spring _____ Summer

Academic year 19____ - 19_____

Projected graduation date _____

Advisor's Name _____

Advisor's Campus Address _____

ADMISSIONS INFORMATION (CONT)

COLLEGE OR PROGRAM CLASS (Circle one)

_____ **Medicine** M1 M2 M3 M4

_____ **Pharmacy** P1 P2 P3 P4

_____ **Nursing**
 Omaha NS1 NS2 NS3 NS4 NS5 NRN
 Lincoln US1 US2 US3 US4 US5 URN
 Kearney KS1 KS2 KS3 KS4 KS5 KRN
 Scottsbluff WS1 WS2 WS3 WS4 KS5 WSN

_____ **Dentistry** D1 D2 D3 D4 Grad

_____ Dental Hygiene DH3 DH4

Allied Health Professions

_____ Physician Assistant PA3 PA4 PA5

_____ Physical Therapy PT3 PT4 PT5

_____ Medical Technology 4

_____ Radiography 2 3 4

_____ Radiation Therapy Technology 4

_____ Diagnostic Medical Sonography 4

_____ Nuclear Med Technology 2 3 4

_____ Medical Nutrition 5

_____ Cytotechnology 5

_____ Clinical Perfusion 5 6

Graduate College

_____ Program _____

Anticipated graduation date _____ Degree anticipated _____

DISABILITY INFORMATION (check those which apply)

vision hearing speech mobility medical psychological learning
 other _____

Post-secondary institutions at which you previously received accommodations: Dates/ from-to

Describe accommodations received at previous post-secondary institutions.

Have you ever received services from **VOC REHAB**? Y N

Dates from _____ to _____

Voc Rehab

Counselor _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Person from whom we may expect **MEDICAL** documentation of your disability.

Name _____ Title _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Description of
disability _____

CLASSROOM ACCOMMODATIONS TO FACILITATE ACADEMIC GOALS

Testing Accommodations

- _____ All exams including pop quizzes
 - _____ Separate, quiet exam room
 - _____ Extended time ___ LD - 150% ___ ADD - 120%
 - _____ Proctor to read test questions
 - _____ Proctor to assist with scantron answer sheets
 - _____ Sign Language Interpreter
 - _____ Tape recorder
 - _____ Large print
 - _____ Braille
 - _____ Other
-
-

_____ Assistance with Note Taking

_____ Audio Tape Classroom Lectures

_____ Media Accommodations

Difficult Media

Media Accommodations

- | | |
|--------------------------|-------|
| _____ Fine print | _____ |
| _____ Ditto copies | _____ |
| _____ Chalkboard | _____ |
| _____ Overhead projector | _____ |
| _____ Transparency | _____ |
| _____ Text book | _____ |
| _____ Other | _____ |

CLASSROOM ACCOMMODATIONS (CONT)

Facility Accommodations

___ Accessible Classroom

___ Table height ___ Chair ___ Stool ___ Podium

___ Other _____

___ **Other Accommodations (describe)**

REQUEST FOR ACCOMMODATION

Based upon diagnostic documentation reasonably requested by the University of Nebraska Medical Center, which I agree to supply, I hereby request the accommodation described above. I understand that this request must be submitted in order that the Coordinator is provided a reasonable amount of time to evaluate and arrange for any accommodation indicated. Should I fail to submit this in a timely manner, I understand that I may not receive my accommodation at the time I desire.

Student Signature

Date



**SERVICES FOR STUDENTS WITH
DISABILITIES**

RELEASE OF INFORMATION

I, _____,
SSN _____

hereby authorize the Coordinator of Services for Students with Disabilities to consult and/or share information regarding my disability and/or accommodation request with such persons that have reasonable need to know for the purpose of arranging and evaluating the need for accommodations during my enrollment at the University of Nebraska Medical Center:

I understand that this permission may be revoked by submitting such revocation in writing to the Coordinator, Services for Students with Disabilities.

Signature

Date

Witness

Date