

UNIVERSITY OF NEBRASKA MEDICAL CENTER

**REQUEST FOR SERVICES
STUDENTS WITH DISABILITIES**

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 _____

Student Name _____

Birth date _____ SS# ____/____/____

Mailing Address _____

City _____ State _____ Zip _____

Phone (____) _____

Campus mail box (if available) _____

ADMISSIONS INFORMATION

Enrollment status

____ Currently enrolled student at UNMC ____ Accepted for enrollment (date: _____)

____ Other _____

Period for which student is seeking services:

____ Fall ____ Spring ____ Summer Academic year 20____ -20____

____ Until graduation (projected date _____) ____ Other _____

Advisor's Name _____ Advisor's Contact Information _____

ADMISSIONS INFORMATION (CONT)

COLLEGE OR PROGRAM

_____ **Medicine**

_____ **Pharmacy**

_____ **Nursing**

_____ Omaha

_____ Lincoln

_____ Kearney

_____ Scottsbluff

_____ Norfolk

_____ **Dentistry**

_____ Dental Hygiene

_____ **Allied Health Professions**

_____ Physician Assistant

_____ Physical Therapy

_____ Medical Technology

_____ Radiography

_____ Radiation Therapy Technology

_____ Diagnostic Medical Sonography

_____ Nuclear Med Technology

_____ Medical Nutrition

_____ Cytotechnology

_____ Clinical Perfusion

_____ **Graduate College** _____

Program _____

Anticipated graduation date _____ Degree anticipated _____

DISABILITY INFORMATION (check those that 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 fr _____ to _____

Voc Rehab Counselor _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Professional from whom we may expect documentation of your disability:

Name _____ Title _____

Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Description of Disability:

CLASSROOM ACCOMMODATIONS TO FACILITATE ACADEMIC GOALS

_____ Testing Accommodations

_____ Low distraction environment

_____ Extended test time: _____ LD - 150%

_____ Sign Language Interpreter

_____ Large print

_____ Braille

_____ Other _____

_____ Audiotape Classroom Lectures

_____ Media Accommodations

Difficult Media

_____ Fine Print

_____ Chalkboard

_____ Power Point

_____ Text Book

_____ Other

Media Accommodations

CLASSROOM ACCOMMODATIONS (CONT)

____ Facility Accommodations

____ Accessible Classroom

____ Table Height

____ Chair

____ Stool

____ Podium

____ Other _____

____ Other Accommodations:

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

UNIVERSITY OF NEBRASKA MEDICAL CENTER

SERVICES FOR STUDENTS WITH DISABILITIES

RELEASE OF INFORMATION

I, _____,

Date of Birth _____

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

Return this completed form to: Services for Students with Disabilities at UNMC in Omaha, NE, via mail or fax:

Box 984255 NE Medical Center
Omaha, NE 68198-4255

Fax: 402-559-9671
Telephone: 402-559-7276