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/ fr – 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

____ Separate, quiet exam room

____ Extended test time: _____ LD - 150% _____ ADD - 120%

____ Sign Language Interpreter

____ Large print

____ Braille

____Other_____

____ Assistance with note-taking

____ Audiotape Classroom Lectures

____ Media Accommodations

Difficult Media	Media Accommodations
_____Fine Print	_____
_____Chalkboard	_____
_____Power Point	_____
_____Text Book	_____
_____Other	_____

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