Brenau University
1878

Office of Accessibility Services

REASONABLE ACADEMIC ACCOMMODATION REQUEST AND PROVIDER VERIFICATION FORM

Students, please return this completed form to: The Office of Accessibility Services
Confidential Documentation Email: accommodations@brenau.edu
Fax: 770-297-5883

To be completed by the student:
Student Name: _____
Student ID #: _____
Student DOB: _____

The Brenau University Office of Accessibility Services is responsible for providing reasonable academic accommodations to students with disabilities who have a verifiable need. In order to evaluate requests for accommodations or auxiliary aids under the Americans with Disabilities Act and under Section 504 of the Rehabilitation Act of 1973, students must provide adequate documentation to our office. Any documentation provided to our office is strictly confidential and used solely for the purposes of determining reasonable accommodations. The Director will reach out to the student with questions and engage in an interactive process upon receipt. Reasonable accommodations may include academic adjustments, auxiliary aids, services, or modifications. Accommodations cannot fundamentally alter course or program requirements or constitute an undue hardship for the institution. Accommodations do not guarantee academic success and are not intended as a substitute for the treatment of medical or psychological conditions. The student remains responsible for learning subject knowledge, demonstrating mastery of course content, and meeting the same academic standards required of all students. Please note there is a separate form and process for requesting Emotional Support Animals (ESAs) or other housing-related accommodations. Please contact the Director if information is needed regarding the housing accommodations application process.

What reasonable accommodations or auxiliary aids are you requesting at this time (you may attach a separate sheet of paper, if needed):

_____
_____
_____
_____
_____
_____
_____

***In lieu of the medical provider verification portion of this form, students may submit one of the following: complete psychological evaluation dated within the last 2 years, IEP plan dated within the last 3 years, or a letter from the current treating medical/mental health provider that provides answers to each of the questions asked by this form and is dated within the last year.**

To be completed by treating medical/mental health service provider:

Providers, please provide specific information on how the diagnosis and resulting limitations are likely to affect the student's college work in the classroom (or internship/fieldwork settings, if applicable). PLEASE REVIEW YOUR FILES, SEND ORIGINAL TESTING/DIAGNOSTIC DOCUMENTATION/PSYCHOLOGICAL EVALUATION AND/**OR RESPOND IN DETAIL TO THE FOLLOWING QUESTIONS:**

1. What is (are) your patient's diagnosis(es)? (International Classification or Diseases (ICD 10) and/or Diagnostic & Statistical Manual Fifth Edition (DSM-V):

_____
_____
_____
_____
_____

2. What length of time has your patient been receiving treatment for this diagnosis with you?

_____
_____

3. What are the current limitations or functional impairments this diagnosis creates for your patient? Are the limitations permanent or will there be changes expected over time?

_____
_____
_____
_____

4. How are the limitations/impairments likely to impact your patient in an academic classroom and/or internship/fieldwork setting?

_____
_____
_____
_____
_____
_____

5. Please indicate any medication side-effects that may affect your patient in an academic and/or internship/fieldwork setting:

_____
_____
_____

6. What <u>specific recommendations</u> do you have regarding how your patient could be reasonably accommodated in the classroom and/or internship/fieldwork setting?

_____
_____

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7. Additional Comments:

_____
_____

Provider Name, license number/credentials (please print):

_____

Signature of Provider:_____**Date:** _____

Phone number: _____

Please attach your business card:

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