MOREHOUSE
SCHOOL OF MEDICINE

Disability Accommodation Request Form

Office of Disability Services
720 Westview Drive, NCPC Room 408
Atlanta, GA 30310
Phone: (404) 756-5200
E-Mail:ODS@msm.edu

Today's Date: _____

Student Full Name: _____ Date of Birth: _____

Social Security #_____

Address _____
Street City State Zip

Telephone Number: _____ Cell Number: _____

Current E-mail Address_____

Classification: _____Prospective Student Semester you will begin: _____

_____Current Student

What is the nature of your impairment? (Check all that apply)
_____ Learning Disability
_____ Attention Deficit/Hyperactivity Disorder
_____ Medical/Physical Impairment
_____ Psychological Impairment Other _____

Please list in the space below and/or on the attached sheet the accommodation(s) you will likely request. Explain why and how it relates to your disability/impairment:

_____

_____

In what semester are you requesting these accommodations to begin? _____

RELEASE OF INFORMATION

In order to explore possible coverage and reasonable accommodations, it is at times necessary for the Office of Disability Services to make appropriate disclosures of the documentation the student has submitted to our office (DARF, Medical Verification Documentation, diagnosis, personal requests/statements) to providers such as licensed physicians, psychologists or other qualified professionals, and to discuss the student's impairment with other faculty and professional staff at MSM on a need-to-know basis. I hereby give permission for the Office of Disability Services to exchange information regarding the documentation I have submitted to the ODS with my provider(s) (physician, psychologist, or other qualified professional), and to discuss my impairment with the School's faculty and professional staff. This authorization will remain in effect for the duration of the student's enrollment. I understand that I may revoke this release of information privilege at any time by informing the ODS. I understand that this information is desired in order to assist those who are helping with my education and request for accommodation(s), and that my refusal to authorize consent may result in a denial of specific accommodations. I also understand that my disability documentation will be kept on file for five years and that I should keep a copy of any records pertaining to my disability.

_____ _____
(Student Signature) (Date)

Requested Accommodations

Please indicate the accommodation(s) you are requesting. Academic accommodations and other services are addressed and provided on an individual basis based on the documents received from a licensed professional.

- ☐ Letter listing approved accommodations for students to provide to faculty
- ☐ Special meeting with Course Instructor for breakdown in Syllabi and/or assignments
- ☐ Extended time, readers, or scribes for in class coursework and examinations
- ☐ Alternative testing environment
- ☐ Enlarged-print exams
- ☐ Note takers
- ☐ Interpreters for the deaf
- ☐ Assistive technology
- ☐ Supportive counseling
- ☐ Accessibility information
- ☐ Registration assistance
- ☐ Referral to other campus and community resources
- ☐ Consultation with faculty and staff regarding on-campus situations which constitute an accommodation challenge
- ☐ Other Accommodations not listed above:

_____