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Student Accessibility Services Accommodation Application

Please return the completed application to: Brandi Crawford, Director of Accessibility, Gwynedd Mercy University, 1325 Sumneytown Pike, P.O. Box 901, Gwynedd Valley, PA 19437-0901. Email: Crawford.b@gmercyu.edu

Date_____ Student Name_____ Date of Birth_____

Permanent Address_____ Campus Address _____

_____ _____

_____ _____

Phone: _____ Cell: _____

GMC email:_____ Email: _____

Program of study/major_____ Class Yr. _____

Undergraduate _____ Graduate _____ On-line_____ Accelerated Program_____

I am requesting accommodations for:

___Academics Only **____Housing Only** **____Academics and Housing**

due to (select all that apply):

____Learning Disability _____ ADD/ADHD _____ Psychological Disability
____Neurological Disability _____ Physical Disability

Before application can be reviewed, the entire packet needs to be submitted in full.

Packet checklist:

Application (page 1)_____
Student section (page 2)_____
Release of information (page 3)_____
Healthcare Professional Form (page 4 and 5) _____ *Do Not Fill Out For Learning Disability
Learning Disability requires psycho-educational evaluation (IEP is supplemental)_____

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Student Section

Please provide a brief description of your diagnosis/disability:

_____

_____

_____

List the accommodations you are requesting:

_____

_____

_____

List accommodations used in the past and note how helpful they were:

_____

_____

_____

If you are currently taking medication to help you with your disability, please state what medication you take, dosage, frequency, and how it helps you:

_____

_____

_____

Please provide information about other support services or strategies you utilize that are helpful to you (tutoring services, support groups, etc.):

_____

_____

_____

Please provide any additional information that should consider regarding your request:

_____

_____

_____

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Release of Information

In support of my request for reasonable accommodations, I have provided you with documentation of my condition. By signing this Authorization, I (please print name in space provided) _____ authorize you to release this information to those staff and faculty of Gwynedd Mercy University properly involved in evaluating and responding to my request for accommodation (for example: campus health, resident life, counseling services, etc.).

By signing this Authorization I also give permission to the Accessibility Coordinator to discuss my condition and request for accommodation with those professionals who have evaluated or diagnosed the condition for which I am seeking accommodation and those with whom I am currently involved in medical/therapeutic support (for example: primary care physician, specialist physicians, psychiatrist, psychologist/counselor, tutor, etc.).

I understand that this authorization will remain in effect until (usually one year form the date signed)_____ .

_____ _____

Signature of Student Date

_____ _____

Signature of Director of Accessibility Date

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HEALTH CARE PROFESSIONAL FORM

Those seeking accommodations for only a Learning Disability do not have to fill out this form.

Student's information

Name:_____

Address:_____

_____

Phone (home):_____

Phone (cell):_____

INSTRUCTIONS – This form must be completed by a HEALTH CARE PROFESSIONAL
The above-named student is requesting accommodations at Gwynedd Mercy University. In order to respond to the student's request, we require that you complete the information below. Please complete this information, attaching additional pages if necessary.
Please note that this form must be completed prior to receipt of accommodations.

Professional's Contact Information (Please Print): **Physician's Stamp:**

Name:_____ Address:_____

Telephone #: ( )_____ _____

Fax #: ( ) _____ _____

License #: _____

Disability type (please check at least one):

Physical_____ Neurological _____ ADHD _____ Psychological _____

PRINT CLEARLY (if more space is needed, please use office letterhead)

What is the student's relevant diagnosis/impairment (include diagnostic code)? How long has this student had this diagnosis?

_____

_____

Is this student currently being treated for this diagnosis? __ Yes __ NO

Is the impairment expected to last six months or longer? __ Yes __ NO

Describe the present symptoms, their frequency and severity, and how the disability interferes with one or more major life activities.

_____

_____

What treatment and/or medication(s) is the student undergoing? Please list medications and dosages.

_____
_____
_____

Do you expect these symptoms to continue for the foreseeable future? ____yes ____no
If no, when do you expect the symptoms to abate?

_____
_____

How will the student be able to manage these symptoms in other campus environments (e.g. classrooms, dining hall, library)?

_____
_____

What specific symptoms does the student have that, in your judgment, **prohibit** the student from being able to live safely in a standard on-campus residence hall.

_____
_____

For episodic conditions, how frequent are the episodes, and what is their duration and severity?

_____
_____
_____

What accommodations are reasonable and appropriate (i.e. to maintain general wellness) for a college student?
_____
_____

Are there other effective means that would achieve similar benefits as the requested accommodation?
_____
_____

Is the impact of the condition life threatening if the request is not met? ___ Yes ___ No

___I have attached the documentation with the results of evaluations which led to this diagnosis.

Professional's Signature: _____ Date: _____

Print name: _____

Please return the completed form to:
Brandi Crawford
Director of Accessibility
Gwynedd Mercy University, 1325 Sumneytown Pike, P.O. Box 901,
Gwynedd Valley, PA 19437-0901.
Email: Crawford.b@gmercyu.edu

For Administration Only

Health & Wellness Director _____approved _____not approved Reason: _____

Accessibility Coordinator _____ approved _____not approved Reason: _____