APPENDIX A

APPLICATION FOR ACCOMMODATIONS & SERVICES

*Please allow **up to 21-days** for the Office of Student Disability Services (OSDS) to review your application and supporting documentation. **Please note that your application cannot be reviewed until documentation is received.** General Documentation Guidelines are outlined below. After OSDS has reviewed your application, you will be contacted via e-mail or by phone so that we may engage you in an interactive dialogue relative to your application. Please contact OSDS if you have questions regarding the OSDS application process.*

Section I: Student Information

Name: _____ **Today's Date:** _____

Student ID Number:_____ **Date of Birth:** _____

Preferred Title (Mr., Ms., etc.):_____

Permanent Address:_____
(Street & Apt. #)

_____
(City) (State) (Zip)

Local Address: _____
(Street & Apt #) (City) (Zip)

Phone # (Cell):_____

Phone # (Permanent):_____

Touro E-mail Address (If Available):_____

Other E-mail Address:_____

Section II: Programmatic Information

Touro College school and program you are attending: _____

_____

Anticipated Graduation Date: _____ First Semester at Touro: _____

Please briefly describe your program. Be sure to include information about fieldwork, classroom, clinical or laboratory components, comprehensive examinations, a thesis/dissertation, or other requirements that may be impacted by your disability or may need reasonable accommodations. If your program has published technical standards, please attach them:

_____

_____

_____

_____

Section III: Disability Related Information

Please answer the following questions regarding your disability and how it impacts your ability to learn, attend, or participate in College life.

1. Please indicate your disability category(ies). Check all that apply:

☐ Learning Disability
☐ Attention Deficit/Hyperactivity Disorder (ADHD)
☐ Chronic Medical Condition
☐ Physical Disability (mobility impairment)
☐ Psychiatric Disability (psychological or mental illness)
☐ Visual Impairment or Blindness
☐ Deaf or Hard-of-Hearing
☐ Substance Abuse (Recovery)
☐ Traumatic Brain Injury
☐ Temporary Injury/Condition
☐Undiagnosed Condition

- Please describe:_____

☐ Other

- Please specify:_____

2. Specify the diagnosis or type of disability based on the category above:

_____

3. Please identify what major life activity(ies) is/are affected by your condition(s):

_____

_____

4. What mitigating measures have you used to address your condition(s)? Mitigating measures are any device, treatment or medication, assistive technology, reasonable accommodations, and/or compensatory strategy that reduces the impact of disability.

_____

_____

5. Please check all that apply:

- ☐ I use a wheelchair.
- ☐ I use assistive mobility devices (braces, crutches, cane, or prosthesis).
- ☐ I wear a hearing aid.
- ☐ I need to read lips of instructors.
- ☐ I have difficulty reading the blackboard/whiteboard.
- ☐ I have difficulty taking notes in class.
- ☐ I have difficulty writing.
- ☐ I have difficulty standing for long periods of time.
- ☐ I tire easily when I walk distances.
- ☐ I have difficulty walking up/down stairs.
- ☐ Please describe any other mobility or disability related difficulties you are currently experiencing:

  _____

  _____

- ☐ Other

  _____

  _____

6. Are you currently taking any medication related to your disability or medical condition?

☐Yes ☐No (check only one)

If yes, list all of the medications you are taking: _____

_____

_____

If yes, please also list any side-effects of the medications that you are taking and their positive and negative impact on your academic/cognitive abilities and/or other activities: _____

_____

_____

7. Please check all of the reasonable accommodations that you are requesting:

☐ Testing Accommodations
- Please specify:_____

☐ Classroom Accommodations
- Please specify:_____

☐ Communication Accommodations
- Please specify:_____

☐ Other Accommodations
- Please specify: _____

8. Briefly describe why you are requesting the above accommodations:

_____

_____

9. Please list any services/accommodations you received throughout your education (Please note that while such services do not necessarily carry over to your current program, the information is helpful to give OSDS background information on your disability-related needs.)

Institution: _____ Years Attended: _____

Accommodation(s) Received: _____

Institution: _____ Years Attended: _____

Accommodation(s) Received: _____

Section IV: Agency Information

Do you receive services from any of the following agencies?

☐ Vocational Rehabilitation Services
- Specify State and Agency: _____

☐ Veterans Administration (VA)

☐ Other: _____

If yes, please provide the following information:

Counselor's name: _____

Office Address or Location: _____

Services currently receiving from Agency: _____

_____

_____

Section V: Professional Assessment of Mitigating Measures

I, _____, give Touro College permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, Section 504 of Rehabilitation Act, and all applicable State and Federal laws. I understand that all information obtained during this process will be maintained and used in accordance with the ADA, including its confidentiality requirements. I certify that I have read and reviewed the description of the program and have been informed of the essential

requirements. I further certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that Touro College may require me to undergo testing or evaluation by medical personnel retained by Touro College for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to meet essential academic functions and requirements with or without reasonable accommodation.

_____ _____

Signature of Requestor/Student* Date

*Important Notes:

Reasonable accommodations cannot be applied retroactively.

Provision of reasonable accommodations during our program is not a guarantee of successful graduation, licensure, certification or continued certification. Students must successfully satisfy program requirements and meet the program's rigors. Testing providers and licensing and certification agencies, boards and organizations have their own reasonable accommodation requirements. Reasonable accommodations, if any, received by the student at Touro College are not binding on those providers, agencies, boards or organizations. The student is solely responsible to investigate, apply for and acquire accommodations with any necessary providers, agencies, boards or organizations. Touro College hereby expressly disclaims any liability in such event those providers, agencies, boards or organizations do not grant the student accommodations – such risk is borne exclusively by student.

[THE FOLLOWING IS TO BE FILLED OUT BY A LICENSED PROFESSIONAL]
In comparison with the average person in the general population, please have your medical or other licensed professional rate how your major life activity(ies) is affected by your condition(s) both with and without mitigating measures:

With Mitigating Measures	Without Mitigating Measures
☐ Mild	☐ Mild
☐ Moderate	☐ Moderate
☐ Substantial	☐ Substantial
☐ Severe	☐ Severe

_____

Print Name of licensed professional providing this rating

_____ _____

Professional's Signature Date

Medical Records Review Acknowledgement, Waiver and Consent

I, _____(student), give Touro College permission to contact _____ (health care provider) and have executed an Authorization For Use Or Disclosure Of Health Information To Touro College.

I understand the reason for this contact is to advise Touro College about my educational needs and functional abilities and limitations in relation to my educational goals and functions. I understand that the College may provide _____(health care provider) with specific information about the program if requested, including the essential functions and specific requirements. I authorize Touro College to discuss the program and my participation in it, including sharing my education record.

I understand that Touro College may use experts or outside reviewers to review my records; I hereby consent to such additional disclosure. My Authorization For Use Or Disclosure Of Health Information To Touro College. shall be read to include these additional disclosures, if any.

_____ _____

Student Signature Date

_____ _____

Witness Date