

**Instructions to students requesting accommodation(s):**

1. Complete this form in its entirety, stating specifically your accommodation need(s). When completing this form, please review the documentation guidelines identified on the Rutgers Office of Disability Services website:

https://ods.rutgers.edu/students/documentation-guidelines

1. The form should then be returned directly to:

**Julie Ferguson, Asst. Dean for Student Affairs**

**Rutgers New Jersey Medical School**

**185 S. Orange Ave., MSB B640**

**Newark, NJ 07103**

Alternatively, this form may be faxed to: (973) 972-6930.

1. Provide the name of a health care provider who can document knowledge of the condition and the appropriateness of the accommodation(s) you are requesting, if applicable.
2. Give a copy of the provider documentation form (page 2) to your health care provider so s/he can complete it. Your healthcare provider should follow documentation guidelines identified on the Rutgers Office of Disability Services website:

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4. If you have any questions about the accommodations process, please contact Julie Ferguson at

(973) 972-4640 or julie.ferguson@rutgers.edu.

**RUTGERS NEW JERSEY MEDICAL SCHOOL**

**REQUEST for REASONABLE ACCOMMODATION(S) to PERFORM the ESSENTIAL FUNCTIONS for ADMISSION, MATRICULATION and PROGRAM COMPLETION**

**Student Name: UIN #:**

**Address: Phone number and email:**

**Date of matriculation: Current Class:**

**Type of accommodation: DISABILITY**   **Learning □ Physical □ Pregnancy □ Psychological □**

 **RELIGIOUS □**

**Please check one:** Initial request **□** Request for renewal **□**

**Accommodation(s) needed:**

**Please indicate the start and end dates for the accommodation(s):**

Have you previously received accommodations at NJMS or elsewhere? YES NO

If you have previously received accommodations: where and when were they granted?

If you have previously received accommodations, what were the accommodations (please be specific)?

***Please provide the name and contact information of the health care provider who will document the need for these accommodations:***

**Name: Phone:**

**Address: Email:**

Note: The student making the request for accommodations must obtain documentation from his/her health care provider using the attached form. The student’s request for accommodation is not considered complete until documentation is received from the health care provider.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Student Date

***Rev. 8.4.14***

**Health Care Provider Documentation Form**

In Support of a Request for Reasonable Accommodation(s)

**Name of Student/Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_**

The student is requesting the following accommodations:

****1. Extended time on written examinations of \_\_\_\_\_% additional time for \_\_\_\_\_\_ % total time

****2. Access to a quiet room for examinations, separated from non-disability classmates

****3. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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*--Health Care Provider Completes This Portion--*

Name of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Profession/License: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone and Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of most recent contact with student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This student has been in my care for diagnosis and/or treatment of a medical or mental health condition:

Yes No Dx: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The condition is considered: Permanent Temporary Unknown

It is my opinion that the specific accommodations requested by the student (above) are congruent with and substantiated by the student’s diagnosis and condition: YES NO If NO, please explain: \_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At this time, given the condition and the expected duration or response to treatment, I recommend that accommodations be provided for (circle one):

 3 Months 6 months 1 Year Permanently Other (please specify)

**Please attach supporting documentation, such as reports, etc.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider Date

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