Student Access and Accommodation Services (SAAS)

REQUEST FOR ACCOMMODATION AND SELF-DISCLOSURE

By completing and signing this form and providing it to the Director of Student Success, you agree that you are voluntarily disclosing your disability, and are requesting accommodations to be provided at the Bon Secours Memorial College of Nursing. This process can take up to two weeks, please start this request as early as possible and preferably before the semester begins.

Once this page and the documentation pages (pg. 3-5 below) are completed along with any supplementary documentation and received in the Center for Student Success, you will need to allow time for verification and review. Then you will be contacted for an appointment to meet and discuss accommodations.

Name: _____ Cell: _____

College Email: _____ I.D. # _____

Disability/Medical Condition: _____

_____

_____

Educational History (Please describe any support services you have used in previous academic settings):

_____

_____

_____

_____

_____

I hereby give permission for a representative of the Center for Student Success of the Bon Secours Memorial College of Nursing or a designee thereof the permission to contact the care provider listed in the documentation, in regards to records pertaining to the approval of an accommodation. I also hereby give permission to the care provider listed below to release these records to the Director of Student Success or designee.

Signature: _____Date: _____

Please submit this completed form along with relevant documentation in person, fax, scan or U.S. mail to:

Lydia Lisner
Director of Student Success (Room 233)
Bon Secours Memorial College of Nursing (address/fax below)
Preferred method is scanned to:
lydia_lisner@bshsi.org from your College email account

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DOCUMENTATION OF DISABILITY FORM TO BE COMPLETED BY THE DIAGNOSING CLINICIAN

Bon Secours Memorial College of Nursing
Center for Student Success, Student Access and Accommodation Services
ACCOMMODATION VERIFICATION FORM
C O N F I D E N T I A L

1. **Student's Name: _____Today's Date: _____**
2. **Diagnostic Information**
   a. DSM-V Diagnosis: Primary: _____
      Secondary: _____
   b. Date of Diagnosis: _____Full Title of Diagnosis: _____
   c. DSM-V Diagnosis: Primary: _____
      Secondary: _____
   d. Date of Diagnosis: _____Full Title of Diagnosis: _____

   Please include all records relating to the diagnoses above. For informal assessments or observations, include a note on professional letter head detailing the diagnostic process as it pertains to the student.

3. **Contact History**
   a. This student has been under a provider's care for this issue since: _____
   b. Date student was last seen: _____

4. **Impact of Condition**
   a. How long is this condition likely to persist? (Permanent/Temporary) _____
   b. How often is the student required to check-in with a provider?
      Once a week Once a month Every 3-4 months Every 6 months
      Once a year As needed Other: _____
   c. Is the student currently taking medication(s) for their symptoms?
      YES NO
      If yes, what medication(s) is the student currently taking? For each medication, describe the side effects and any impact on academic performance. Do limitations/symptoms persist even with medications? *Please print clearly:*

Medication and Dosage	Side Effects	Academic Impact	Symptoms Persist with Medication?

d. Please note to what extent each of the following life activities, learning/time management are affected due to the diagnosis.

1-Unable to Determine 2-No Impact 3-Mild Impact 4-Moderate Impact 5-Substantial Impact

Life Activities					
	1	2	3	4	5
Hearing					
Standing					
Lifting/Carrying					
Sitting					
Sleeping					
Learning/Time Management					
Reading					
Writing: spelling					
Math (quantitative reasoning)					
Processing speed					
Stress Management					
Listening					
Concentration					
Managing distractions					
Memory					
Planning/Organization					
Time Management					
Attending classes regularly					
Timely submission of assignments					

e. What other specific symptoms manifesting themselves at this time might affect the student's ability to access the College of Nursing programming, facilities, and/or academic opportunities?

_____

_____

f. What is the student's prognosis? How long do you anticipate that the student's ability to access the College of Nursing programming, facilities, and/or academic opportunities will be impacted by their disability/condition?

_____

_____

g. Have there been any changes in the student's condition in the past 12 months?
YES (please explain below) NO

_____

_____

h. Do you anticipate any changes in the student's condition in the next 12 months?
YES (please explain below) NO

_____

_____

i. Is there anything else you think we should know about the student's medical condition and their ability to function academically and/or socially in a college environment?

_____
_____
_____

5. **Recommendations by the Diagnosing Clinician**
TESTING ACCOMMODATIONS:

_____
_____
_____
_____
_____

OTHER ACCOMMODATIONS:

_____
_____
_____
_____

6. **Credentials and Signature** (please type or print clearly)

Clinician's Name: _____

Professional Qualifications: _____

Address, City, State, Zip: _____

Phone Number: _____Fax Number: _____

Email: _____License/Cert. Number: _____

Clinician's Signature: _____

Thank you for your time and consideration in the completion of this documentation. This form and any additional records will be confidentially kept in accordance with the Family Educational Rights and Privacy Act (FERPA). Send any/all additional documentation on professional letterhead to: (prefer scanned)

Lydia Lisner, Director of Student Success
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Richmond, VA 23227
CONFIDENTIAL
Phone: (804) 627.5300 Fax: (804) 627.5411 Scan: lydia_lisner@bshsi.org