**Student Access and Accommodation Services (SAAS)**

REQUEST FOR ACCOMMODATION AND SELF-DISCLOSURE

By completing and signing this form and providing it the Office 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.

Once all pages of your form are completed (along with any supplementary documentation) and received in the Office of 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Accommodation(s) Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby give permission for a representative of the Office of 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)

Completed forms can also be 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

Office of 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**
	1. DSM-V Diagnosis: Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. Date of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_Full Title of Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. DSM-V Diagnosis: Primary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. 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.*

1. **Contact History**
	1. This student has been under a provider’s care for this issue since: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. Date student was last seen: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Impact of Condition**
	1. How long is this condition likely to persist? (Permanent/Temporary) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	2. 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. 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?

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication and Dosage** | **Side Effects** | **Academic Impact** | **Symptoms Persist with Medication?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

* 1. 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 |  |  |  |  |  |

* 1. 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?

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

* 1. 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?

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

* 1. Have there been any changes in the student’s condition in the past 12 months?

YES (please explain below) NO

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

* 1. Do you anticipate any changes in the student’s condition in the next 12 months?

YES (please explain below) NO

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

* 1. 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?

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

1. **Recommendations by the Diagnosing Clinician**

**TESTING ACCOMMODATIONS**

|  |  |
| --- | --- |
| Extended time |  |
| Reduced Distraction |  |
| Other: |  |
| **Notes:** |

**OTHER ACCOMMODATIONS**

|  |  |
| --- | --- |
| Ability to record lecture |  |
| Written notes/lecture notes/assignment instructions |  |
| Extended time on assignments |  |
| Other: |  |
| **Notes:** |

1. **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:

Lydia Lisner, Director of Student Success

Bon Secours Memorial College of Nursing

8550 Magellan Parkway, Suite 1100

Richmond, VA 23227

CONFIDENTIAL

Phone: (804) 627.5300 Fax: (804) 627.5411 Scan: lydia\_lisner@bshsi.org