## Student Access and Accommodation Services (SAAS)

REQUEST FOR ACCOMMODATION AND SELF-DISCLOSURE

By completing and signing this form and providing it to Student Access and Accommodation Services, you agree that you are voluntarily disclosing your disability, and are requesting accommodations to be provided at the Bon Secours Memorial College of Nursing. 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 by Student Access and Accommodation Services, you will need to allow time for verification and review. Then you will be contacted for an appointment to meet and discuss accommodations. This process can take up to two weeks, thank you for your patience.

Name: _____ Cell: _____

College Email: _____ I.D. # _____

Disability/Medical Condition: _____

_____

_____

_____

_____

*I hereby give permission for a representative of Student Access and Accommodation Services 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 Assistant Director, Center for Student Success or designee.*

Signature: _____Date: _____

Please submit this completed form along with relevant documentation in person, fax, email/scan or mail to:

Dayna Scarberry
Assistant Director, Center for Student Success (Office 231 – Bon Secours Memorial College of Nursing campus)
8550 Magellan Parkway, Ste 1100, Richmond, VA 23227
Preferred method is scanned to:
Dayna_scarberry@bshsi.org from campus email account

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DOCUMENTATION OF DISABILITY FORM TO BE COMPLETED BY THE DIAGNOSING CLINICIAN

Bon Secours Memorial College of Nursing | Southside College of Health Sciences | St. Mary's School of Medical Imaging

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 email/scan)

CONFIDENTIAL
Dayna Scarberry, Assistant Director, Center for Student Success
Bon Secours Memorial College of Nursing | Southside College of Health Sciences | St. Mary's School of Medical Imaging
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Richmond, VA 23227
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