DISABILITY NOTIFICATION AND ACCOMMODATION REQUEST

Please complete, sign and return this form along with any medical documentation to American University of Health Sciences (AUHS) via e-mail to studentservices@auhs.edu or by mail to the attention of Disability Services in Student Affairs Office.

Please print or type your responses below. Attach extra pages as necessary.

Name (last, first): _____ Date: _____

Address: _____

Phone: _____ Email: _____

AUTHORIZATION: I give American University of Health Sciences (AUHS) permission to explore coverage and reasonable accommodations under the American with Disabilities Act. I understand the information obtained during this process will maintained and used in accordance with ADA and will be kept confidential as provided by applicable laws. I authorize this information to be shared with and AUHS to consult with the Student Affairs Office, those individuals at AUHS having a need to know (such as those individuals providing assistance with respect to the disability accommodation), those required by law, and the medical/mental health professional that provided documentation.

REASONABLE ACCOMMODATION REQUEST:

Please answer the following questions to assist us in understanding the basis and nature of your request for a reasonable accommodation.

A. What is the nature of your disability/limitation and what is the expected duration? It is not necessary to indicate a medical diagnosis or condition.

B. Explain how the disability/limitation affects your ability to perform an essential function as a student:

C. List the accommodations you believe are needed to enable you to perform the essential functions:

D. **Has a physician or other health professional recommended a specific accommodation?** YES: ☐ NO: ☐

If YES, please attach a copy of the recommendation.

I hereby certify that the above information is accurate, complete and truthful.

_____ _____

Student Signature Date