Johnson University Office Disability Services

Request for Reasonable Accommodations
(Must be completed by student's physician)
7900 Johnson Drive
Knoxville, Tennessee 37998
Office: 865-251-2426 Fax: 865-251-2337

Today's Date _____
Student Name_____DOB:_____

Diagnosis

Diagnosis	Date diagnosed or when symptoms first appeared:
Secondary Diagnosis	Date diagnosed or when symptoms first appeared:

If applicable, please specify the following for DSM 5 diagnosis (es):

AXIS 1:_____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Does student currently takes medication for their illness or symptoms? If so, please describe any effects or side effects that may impact the student's ability to complete academic activities: _____

_____

Which major life activity does this individual's disability substantially limit?

- ☐ **Breathing**
- ☐ **Caring for one's self**
- ☐ **Hearing**
- ☐ **Learning**
- ☐ **Manual Tasks**
- ☐ **Vision**
- ☐ **Walking**

Suggested Academic Accommodations:
The above student will benefit from the following academic accommodations:

- ☐ Extra time to complete:
  - ☐ Coursework
  - ☐ Assignments
  - ☐ Quizzes, tests, and exams
- ☐ Reduced distraction testing environment
- ☐ Scribe/Typist
- ☐ Larger font for materials and assessments

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Academic Accommodations continued:

- ☐ Pre-printed material/note taking assistance
- ☐ Allow student to leave class if symptoms/pain worsen during class time
- ☐ Student may request a reader for coursework and assessments as needed
- ☐ Alternate method of attending chapel
- ☐ Other recommendations: _____

Physical Limitations/Accommodations
The above student should adhere to the following recommendations regarding physical and athletic participation (checked items apply):

- ☐ May request access to handicapped parking
- ☐ May need assistance to access classes
- ☐ May need access to elevators
- ☐ May take alternative course due to physical limitation that prevent student in participating in university courses that involve physical activities
- ☐ May need handicapped accessible desk
- ☐ May need more time to transition from class to class (if classes are back to back)
- ☐ Other recommendations: _____

Student Authorization for Release of Medical Information
I hereby authorize the information on this form to be released to the Office of Disability Services at Johnson University

Student Signature _____ Date _____

Witness Signature _____ Witness Printed Name _____

Accommodations Plan completed by _____
(MD, APRN, or PA signature)

Printed Name _____

Please return this form to the address above. ALL INFORMATION IS CONFIDENTIAL AND FOR PROFESSIONAL USE ONLY. Please be aware, however, that under FERPA the documents are subject to review as part of the education records of the Office of Disability Services.