

UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
REQUEST FOR ACADEMIC ACCOMODATIONS

**PLEASE FILL OUT COMPLETELY.
ONCE COMPLETED, PLEASE FAX OR MAIL TO
DIRECTOR, STUDENT/EMPLOYEE HEALTH,
UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
2500 NORTH STATE STREET
JACKSON, MS. 39216
FAX # (601)984-1189**

Today's Date _____

Student's Full Name _____

Student's Date of Birth _____

School (Student Program), e.g., Univ. Miss. Med. Ctr. (Medicine)

Healthcare provider/evaluator information:

Name _____

Title _____

Office Telephone Number _____

Licensure or certification number _____

**Brief summary of experience in diagnosing and treating learning
problems, psychiatric or psychological disorders:** _____

Date of initial evaluation of student _____

Date of most recent evaluation/review of student _____

***Most recent evaluation/review MUST be within the past 3 years.**

Are you a family member of the student? **yes** **no**

Student Assessment:

Specific DSM-IV Diagnosis (or Diagnoses) _____

How does this diagnosis limit the individual's major life activities, including learning? _____

Assessment tools used to evaluate Ability/Aptitude, Achievement, Attention and Concentration, Functional Limitations.

***Please note you may submit actual test results but they must be typed or printed on professional letterhead and must be dated and signed.**

Recommendations for Accommodations:

Please recommend specific accommodations that link the recommended accommodation(s) to the specific functional limitations of the student. Please be as specific as possible. For example, if extra time for testing is recommended, indicate that the student should be given “time and a half” on tests.

Healthcare Provider/Evaluator Signature:

For Office Use only:

Date Request received in Student/Employee Health_____

Date Request for Accommodations forwarded to School_____