

**UNIVERSITY OF MISSISSIPPI MEDICAL CENTER**  
**REQUEST FOR ACCOMMODATIONS**

**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)**  
\_\_\_\_\_

**A. Healthcare provider/evaluator information:**

**Name** \_\_\_\_\_

**Title** \_\_\_\_\_

**Office Telephone Number** \_\_\_\_\_

**Licensure or certification number** \_\_\_\_\_

**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

**B. If request for accommodations is of an ACADEMIC nature, please fill out the following information. If request is for PHYSICAL accommodations skip to C.**

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

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**Specific DSM-IV Diagnosis (or Diagnoses)**

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

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

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

**C. Diagnoses (list all)**

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

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**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. If the accommodation is of a PHYSICAL nature, be as specific as possible including an estimate of the length of time needed for the accommodation (if temporary) for example, permanent disability parking assignment to accommodate special needs van.**

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**Healthcare Provider/Evaluator Signature** \_\_\_\_\_

**Healthcare Provider/Evaluator Printed Name** \_\_\_\_\_

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**For Office Use only:**

**Date Request received in Student/Employee Health** \_\_\_\_\_

**Date Request for Accommodations forwarded to School** \_\_\_\_\_