



ACCOMMODATION REQUEST FORM
FOR STUDENTS WITH
DISABILITIES

Campus Location:

- ☐ Alamogordo
☐ Carlsbad
☐ DACC
☐ Las Cruces
☐ Grants

SECTION: 1

TO BE COMPLETED BY STUDENT
(You may attached additional sheet of paper to complete sections)

This form will assist with the gathering of information to facilitate the identification of an appropriate accommodation while you attend NMSU. Referred by : ☐Self ☐Other

Student Full Name (Please Print)

Aggie ID

Current Mailing Address:

City

State

Zip Code

Local Phone Number

Cell Phone Number

E-Mail Address

Preferred Contact Method:

☐ Local Phone

☐ Email

☐ Cell Phone ☐ Text Cell (I give staff permission to text my cell phone)

Class / Year (Freshman, Sophomore, etc.)

Major:

Provide the following information if you are a client of another agency such as NM DVR, etc.,

Agency Name

Telephone Number

Do you have a disability or impairment?

☐ Yes ☐ No

If yes, please identify the disability or impairment:

Describe the issues that you are experiencing in your class(es), housing or other campus setting that may require accommodation(s):

The following reasonable accommodation(s) are requested in order to perform the essential academic functions as a student at NMSU:

Authorization for release of information relating to disability accommodation(s):

I hereby authorize _____ (physician, _____ psychologist, psychiatrist, educational diagnostician, other) to release any information requested on this form. By signing this form, I understand that once this request for accommodation(s) is processed, I may be required to provide additional documentation, on a case-by-case basis, of changes in my condition. I fully understand that this request for accommodation(s) is based on NMSU's need for documentation to support my request for services.

I understand that NMSU has no obligation to provide services until appropriate documentation has been received by the appropriate office handling the accommodation function on my campus. I further understand that services may be discontinued should documentation not be received within thirty (30) days of receiving temporary services (unless there are extenuating circumstances). I authorize NMSU officials (such as staff providing disability accommodation services, Vice President for Student Service or Student Affairs, Executive Vice President/Provost, General Counsel, Office of Institutional Equity Executive Director, Student Health Center Director etc.) to: verify, discuss, transmit, or release on a "need to know basis only", the contents of this request form with my physician, psychologist, diagnostician, practitioner, and/or other authorized NMSU personnel. This document will be treated as a confidential medical record. I, the undersigned, authorize the staff providing disability accommodation services to contact relevant NMSU system disability services staff to share information pertaining to my accommodation(s) for the purpose of coordinating appropriate services and determining any necessary and reasonable academic adjustments.

Student Signature

Date

SECTION 2:		To be completed by the physician, psychologist, diagnostician, or other practitioner (please refer to section 1 for authorization to release information) (You may attached additional sheet of paper to complete	
Student Name (Please print):		Aggie ID	
To the physician, psychologist, psychiatrist, audiologist, diagnostician, or practitioner:			
<p>The above named student has informed New Mexico State University (NMSU) that their disability/impairment prevents them from performing the essential academic functions and/or attending classes regularly unless accommodation(s) are provided. We request receiving sufficient information in order to determine appropriate accommodation(s) in accordance with provisions of state and/or federal laws. For example: 1). for a learning disability, a full diagnostic evaluation is required from a psychologist, psychiatrist or educational diagnostician; 2). for hearing disability, a current audiogram from an ENT or audiologist is required; 3). for a psychological disability, a diagnosis based on a current DSM-V from a psychologist/psychiatrist will be required; and 4). For a physical disability, a diagnosis according to the current ICD from a physician will be required. Recommendations for accommodation(s) are helpful and will be given due consideration.</p>			
Provide a diagnosis of the condition or a brief description of disability:			
Which of the following major life activities/major bodily functions does the disability impair?			
<input type="checkbox"/> Bending	<input type="checkbox"/> Concentrating	<input type="checkbox"/> Lifting	<input type="checkbox"/> Sitting
<input type="checkbox"/> Bladder	<input type="checkbox"/> Digestive	<input type="checkbox"/> Neurological	<input type="checkbox"/> Sleeping
<input type="checkbox"/> Bowel	<input type="checkbox"/> Eating	<input type="checkbox"/> Normal cell growth	<input type="checkbox"/> Speaking
<input type="checkbox"/> Brain	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Reaching	<input type="checkbox"/> Standing
<input type="checkbox"/> Breathing	<input type="checkbox"/> Hearing	<input type="checkbox"/> Reading	<input type="checkbox"/> Thinking
<input type="checkbox"/> Caring for Self	<input type="checkbox"/> Immune system	<input type="checkbox"/> Reproductive	<input type="checkbox"/> Toileting
<input type="checkbox"/> Circulatory	<input type="checkbox"/> Interacting with others	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Walking
<input type="checkbox"/> Communicating	<input type="checkbox"/> Learning	<input type="checkbox"/> Seeing	<input type="checkbox"/> Working
Prognosis:			
This Condition is:	<input type="checkbox"/> Permanent	<input type="checkbox"/> Temporary (how long):	
When did you first see the student for the condition?			
Can the student perform essential academic functions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Can the student perform essential academic functions without threat to health/safety of:			

Self:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, please explain:					
What specific major life activities or bodily functions does this condition present that require accommodation(s)?					
What academic accommodations(s) do you suggest for this student?					
Are there any side effects from medication which might affect academic performance?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No			
Class attendance is frequently an essential academic function. Does the condition affect the student's class attendance?					
<input type="checkbox"/> Yes		<input type="checkbox"/> No		If yes, please explain how:	
For what period of time do you recommend that the reasonable accommodation(s) be made?					
I certify that the information provided above is true and correct to the best of my knowledge.					
Practitioner's Signature:			Dat		
Practitioner's Print Name:			Degree, specialty, license number:		
Address:			Telephone Number:		Fax Number: