

DUKE UNIVERSITY
Disability Management System—Student Access Office
REQUEST FOR CONSIDERATION FOR REASONABLE ACCOMMODATIONS—Graduate/Professional
All information obtained in diagnostic medical, psychological, and educational reports will be maintained and used in accordance with applicable confidentiality requirements

I. GENERAL INFORMATION

Name: _____

Duke Unique ID Number: _____ Date of Birth: _____

Address: _____
Street City State Zip

Telephone Number: _____ Current e-mail Address: _____
Area Code Number

Graduate or professional school you will attend or are attending: _____

Classification: _____ Beginning Student _____ Transfer Student (Semester you will begin: _____)
_____ Current Student _____ Other (please explain) _____

II. BASIS FOR REQUEST

What is the nature of your Impairment? (Check all that apply.)

- Learning Disorder(s) Blindness or Low Vision
 Attention Deficit/Hyperactivity Disorder(s) Deafness or Hard of Hearing
 Chronic Health (please explain nature of impairment) _____

 Mobility (please explain nature of impairment) _____

 Psychological Disorder(s) (please explain nature of impairment) _____

 Other (please explain nature of impairment) _____

Please list the accommodations you received at other colleges and universities or from testing agencies:

Please list the accommodations you may request at Duke University:

III. EXCHANGE OF INFORMATION

In order to explore possible coverage and reasonable accommodations, it is often necessary for the staff of the Disability Management System—Student Access Office to discuss the documentation the student has submitted to our office with providers such as licensed physicians, psychologists, or other qualified professionals, and to discuss the student's impairment with Duke University faculty and professional staff.

I hereby give permission for members of the staff of the Disability Management System—Student Access Office at Duke University to exchange information regarding the documentation I have submitted to the Student Access Office with my provider(s) (physician, psychologist, or other qualified professional), and to discuss my impairment With Duke University faculty and professional staff. I understand that my refusal to authorize consent may result in a denial of accommodations.

Student Signature

Date

Return this form to: Dr. Emma Swain, Director
Disability Management System—Student Access Office
Box 90142
Duke University
Durham, NC 27708

Revised 2/5/04
