JEWISH THEOLOGICAL SEMINARY
STUDENT REQUEST FOR ACCOMMODATION

Please complete and return to your Dean via email.

Name:_____ **Date:** _____

Student ID: _____

JTS is committed to providing students with disabilities equal access to its educational opportunities and programs. JTS's consideration of disability and accessibility issues is done in conformance with the Americans with Disabilities Act (ADA) of 1990 as amended, Section 504 of the Rehabilitation Act of 1973 (Section 504), and applicable New York law. The term "disability" may include learning, physical, sensory, psychological, medical, and certain temporary disabilities. JTS provides students with reasonable accommodations in accordance with the ADA/Section 504 and applicable state law.

1. Please describe the accommodation that you are requesting:

_____
_____
_____
_____
_____

2. Why are you requesting an accommodation?

a. □ I have a disability that impacts my ability to complete coursework or satisfy program requirements.
b. □ I have a disability that impacts my daily activities outside the classroom.

Identify the specific disability in question (its diagnosis):

_____
_____
_____
_____
_____

How long have you had that disability?

_____
_____
_____
_____
_____

What is the expected duration of that disability?

___ Permanent___Temporary (for approximately____weeks)

Describe in detail how that disability impacts (1) your ability to complete coursework or satisfy program requirements or (2) daily activities outside the classroom

_____
_____
_____
_____
_____

3. If you completed/listed any restrictions above, have those restrictions been prescribed for you by a qualified medical professional (QMP)?

___ Yes___No (they are my own best estimate of my restrictions)

If "Yes," please provide the following information:

- Name of the QMP who prescribed those restrictions:

  _____

- Type of QMP:

  _____

- Name of QMP's practice group:

  _____

- Address of QMP's office:

  _____
  _____
  _____
  _____

- Telephone number of QMP: _____

- Email address of QMP: _____

4. Other than any QPR you listed above, are there any other health care providers who evaluated or treated your disability in the past two (2) years?

____ Yes____No

If "yes," please provide the following information for each provider (add extra pages if more than one):

- Name of the health care provider:
  _____
- Type of health care provider:
  _____
- Name of the health care provider's practice group:
  _____
- Address of the health care provider's office:
  _____
  _____
  _____
- Telephone number for the health care provider:
  _____
- Email address for the health care provider: ____ _____

5. Has your QPR or health care provider recommended any other measures or accommodations that could be used to address the limitations that are caused by your disability?

___ Yes___No

If "yes," please list all the other recommendations that your QMP or health care provider has made:

_____
_____
_____
_____

6. Please list any other suggestions that you have for accommodating your disability:

_____
_____
_____
_____
_____

7. Is there any other information you would like to share that you believe would be helpful to us in evaluating your request? If so, please list below:

_____

_____

_____

_____

Certification and Permission

Under the Family Educational Rights and Privacy Act (FERPA), JTS may share information and communicate with appropriate university personnel on a need-to-know basis in order to facilitate the process of determining accommodation eligibility and/or implementation. In addition, JTS's evaluation may include review of your documentation by an external consultant engaged by JTS. In limited circumstances, specific information may be required to be disclosed in order to protect individuals in an emergency or to comply with law and/or JTS policies and procedures. The information on this form may be used in aggregate form for reporting purposes.

Permission Agreement**

I give permission for JTS or professionals assisting JTS to speak with or request information from the treating medical professional(s) who provided or will provide documentation (if not attached) to support my accommodation request(s) if needed to make an accommodation decision. I understand that this authorization is voluntary. ___ Yes ____ No

I understand the Dean is not a "confidential resource" (as explained in JTS's Policy on Non-Discrimination and Anti-Harassment) and may be required to report to appropriate JTS personnel situations in which a student expresses intent to harm self or others, and where a student discloses sexual harassment, assault or related violence.

I understand that my accommodation request(s) cannot be considered until appropriate documentation is submitted. I understand JTS's use of the information on this form as stated above and has the right to ask for additional information or documentation. If I responded affirmatively above, I am giving permission for my treating professional to be contacted, if necessary, to determine accommodation eligibility. I understand that the Dean is not a confidential resource.

I understand that all accommodation requests must be supported by appropriate documentation completed by a qualified medical professional.

I am the individual stated in the Request for Accommodation and the information provided is complete, true and accurate.

Signature: _____

Date: _____

Cell phone: _____

Email: _____