

PETITION FOR ACCOMMODATION FORM
(FOR STUDENTS WITH DISABILITIES)

Section 1 To Be Completed By Student

This form is for registering with the Student Accessibility Services (SAS) Office in order receive appropriate support for your disability while attending NMSU.

Gender: M F
Banner ID No _____ Student Name _____ Birthdate _____ Ethnicity _____

Referred by: Self Other
Current Address _____ City _____ State _____ Zip _____

(_____) _____ (_____) _____ NMSU E-Mail Address _____
Local Phone Number _____ Cell Phone _____

Preferred mode of contact: call cell text cell** local phone other phone e-mail
**I DO DO NOT give SAS staff permission to text my cell phone

Class/Year _____ Major: _____
(Freshman, Sophomore, etc)

I am **NOT** registered to vote and would like to register in this office YES NO .

If applicable please list the name and phone number of the agency representative (i.e. NM DVR, NM Commission for the Blind, etc.) of which you are a client.

Name: _____ Number: _____

Have you ever been diagnosed with a disability? YES NO If YES, please specify your disability:

Which of the following major life activities does your disability impair?

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Reaching | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Thinking | <input type="checkbox"/> Bowel |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Working | <input type="checkbox"/> Digestive | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Brain | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Circulatory | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Hearing | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Seeing | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Speaking | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Learning | <input type="checkbox"/> Communicating |
| <input type="checkbox"/> Other: Please specify _____ | <input type="checkbox"/> Reproductive | <input type="checkbox"/> Immune System |

Please describe the issues that you are experiencing in class/housing/other setting that require accommodations _____

I request the following reasonable accommodation(s) in order to perform the essential academic functions of a student at NMSU: _____

AUTHORIZATION FOR RELEASE OF INFORMATION REGARDING 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 petition has been processed, I may be required to provide additional documentation, on a case-by-case basis, of changes in my condition. I certify, under penalty of University disciplinary action, that I have not misrepresented my condition, and that I fully understand that this petition is based on the University's requirements for documentation of the need for services that I am requesting.

I understand that New Mexico State University has no obligation to provide services until appropriate documentation has been received by the SAS Office. Should documentation not be received within thirty (30) days of receiving temporary services from the SAS Office, accommodation services may be discontinued (unless there are extenuating circumstances). I hereby authorize New Mexico State University officials (i.e., SAS, Counseling, Student Health Services, OIE, NMSU General Counsel, Vice President for Student Services, Executive Vice President/Provost, etc.) to verify, discuss, transmit, or release on a "need to know basis" the contents of this petition with my physician, psychologist, diagnostician, practitioner, and/or other authorized University personnel. This document will be treated as a confidential medical record for purposes of confidentiality.

I, the undersigned, authorize Student Accessibility Services to contact relevant campus personnel to share information pertaining to my accommodations for the purpose of coordinating appropriate support services and determining any necessary academic adjustments.

Student Signature _____ Date _____

Section 2 To Be Completed By the Physician, Diagnostician or other Practitioner

(Please refer to Section 1 for authorization to release the following information)

TO THE PHYSICIAN, PSYCHOLOGIST, AUDIOLOGIST, DIAGNOSTICIAN, OR PRACTITIONER: The student has informed New Mexico State University that his/her condition has prevented or will prevent him/her from performing essential academic functions and/or attending classes regularly unless accommodations are provided. We would appreciate receiving sufficient information in order to determine appropriate accommodations in accordance with state and federal laws. For example: 1) for a learning disability, a full diagnostic evaluation is required from a psychologist or psychiatrist or educational diagnostician; 2) for a hearing disability, a current Audiogram from an ENT or Audiologist is required; 3) for a psychological disability, a diagnosis based on a current **DSM** 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 accommodations are helpful and will be given due consideration.

1. Please provide a diagnosis of condition or brief description of disability. _____

2. Which of the following major life activities are impacted?

- | | | |
|--|--|--|
| <input type="checkbox"/> Caring for Self | <input type="checkbox"/> Reaching | <input type="checkbox"/> Learning |
| <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Thinking | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Toileting | <input type="checkbox"/> Bowel |
| <input type="checkbox"/> Working | <input type="checkbox"/> Digestive | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Reading | <input type="checkbox"/> Brain | <input type="checkbox"/> Endocrine |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Circulatory | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Neurological | <input type="checkbox"/> Hearing | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Normal Cell Growth | <input type="checkbox"/> Seeing | <input type="checkbox"/> Concentrating |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Speaking | <input type="checkbox"/> Eating |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Immune System | <input type="checkbox"/> Bending |
| <input type="checkbox"/> Other: Please specify _____ | <input type="checkbox"/> Reproductive | <input type="checkbox"/> Communicating |

2. Prognosis: The condition is: Permanent Temporary; how long: _____ Subject to change? Yes No

3. Is condition: Under Control Not Under Control

4. When was the student first seen by you for this condition? _____

5. Can the student perform essential academic functions without threat to health/safety of Self Yes No Others: Yes No

If no, please explain: _____

6. What specific functional (major life activity(ies)) limitations does this condition present that require accommodations? _____

7. What academic accommodation do you suggest for this student? _____

8. Are there any side effects from medication which might affect academic performance? Yes No
If yes, please describe: _____

9. Class attendance is frequently an essential academic function. Does the condition affect the student's class attendance? Yes No
If yes, please explain how _____

10. For what period of time do you recommend reasonable accommodation(s) be made? _____

I hereby certify that the information provided above is true and correct to the best of my knowledge.

Practitioner's Signature Date

Print Name Degree/Specialty License #

Street Telephone

City State Zip

RETURN FORM TO:

New Mexico State University
 Student Accessibility Services
 P. O. Box 30001, Dept. 4149
 Las Cruces, NM 88003-8001
 Telephone/TTY: (575) 646-6840
 Fax: (575) 646-5222