PATIENT REQUEST FOR REASONABLE ACCOMMODATION(S)

Patient Name: Phone:

Current Medical Diagnosis:

Date of Diagnosis:

Please identify the nature of the patient's physical and/or mental impairment(s) for which they are requesting accommodation(s):

Summary of Requirements:

Students are required to stand for 17-30 hours per week and also have 4 hours of weekly classroom work with exams.

Please describe how the disability will affect their ability to meet school requirements. What are the specific limitations caused by the impairment, and to what extent do they affect daily activities?

Please provide details on the specific accommodations they are requesting and the reason why they are necessary.

Licensed Medical Professional Name

Email **Phone Number**

Medical Professional Signature **Date**