STUDENT DISABILITY SERVICES

Accommodation Request Process

1. Student Contacts the ADA Coordinator

2. Complete required paperwork --application form, release form, etc.

3. Obtain and provide documentation of your disability to the ADA Coordinator.

4. Documentation review by the UBTech case management team to determine eligibility.

5. Decision made regarding eligibility and specific accommodations.

APPROVED-Reasonable accommodations identified. Instructor is notified and provides accommodation. (Allow 45 days)	NOT APPROVED-Contact your ADA Coordinator for more information.

PLAN AHEAD— Please start the process early since accommodations cannot be retroactive. If you have any questions or need clarification of the process, contact Holly Mickelson, ADA Coordinator, at 435-722-6314 or Trinity Long, ADA Coordinator, at 435-725-7103.

STUDENT DISABILITY SERVICES

Request for Accommodation

UBTech is committed to the principle of equal opportunity for students with disabilities. The UBTech Center for Disability Services, as required under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, makes every reasonable effort to provide appropriate accommodations and assistance to students with disabilities.

Name _____ **DOB** _____
Last First MI MM/DD/YY

Phone _____ **Email** _____

What UBTech program/class are you enrolled in? _____

Please describe in detail the nature of your disability and what affect it has on you academically.

_____

_____

What accommodations are you requesting? _____

_____

Do you currently use assistive technology devices or other modifications? ☐ YES ☐ NO

If YES, please list them: _____

How do you accommodate your disability outside of school? _____

_____

Do you have official documentation of your disability? ☐ YES ☐ NO

IF NO, Contact your qualified healthcare professional that treats/diagnosed your condition. The documentation must:

- Be current (completed within the last three years)
- Clearly state the diagnosed disability or disabilities
- Describe the functional limitations resulting from the disability
- Describe the specific accommodations requested and the rationale for such accommodations
- Be typed or printed on official letterhead and signed by the evaluator qualified to make the diagnosis

Documentation will be maintained in a confidential file separate from the academic student record.

I verify that this information is accurate and may be used by personnel, who have an academic need to know, to provide assistance and services to me. I agree to furnish any documentation required and I understand that any costs for obtaining documentation are my responsibility.

Signature _____ **Date** _____

STUDENT DISABILITY SERVICES

INFORMATION RELEASE FORM

Name of Professional: _____

Agency, Company or Clinic: _____

Address: _____ City, State, ZIP _____

I, _____ SSN _____ DOB _____, hereby request that you release complete information concerning my current physical and/or psychological condition to Uintah Basin Technical College for the purpose of providing services and appropriate accommodations while I am a student at the college. Please provide all information as it relates to diagnosis, treatment, capabilities, limitations and recommendations. You are also authorized to answer any questions and discuss my case with my advisor. If you have questions about this request, please call me at _____.

Please **fax or mail** the information to:

Holly Mickelson, ADA Coordinator
Uintah Basin Technical College
1100 East Lagoon Street
Roosevelt, UT 84066
Phone: 435-722-6914 Fax: 435-722-6999

Trinity Long, ADA Coordinator
Uintah Basin Technical College
450 North 2000 West
Vernal, UT 84078
Phone: 435-725-7103 Fax: 435-725-7199

Authorizations to the individual listed above are valid during my enrollment at the college but may be revoked by me, at any time, through a written request to my advisor. Revocation will not affect information received and/or given previously.

I also acknowledge that information regarding my disability and functional limitations may be shared with specific individuals within the college on a need-to-know basis.

Student's Printed Name _____

Student's Signature _____ Date _____

STUDENT DISABILITY SERVICES

Documentation of Disability

COMPLETED BY STUDENT

Student Name _____ SSN _____ DOB _____

Date _____ UBTECH Program _____

Address _____ City, State ZIP _____

Health Care Provider _____

I have submitted a request for a reasonable accommodation to my school under the Americans with Disabilities Act. The law allows my school to conduct an individual assessment of my condition before granting or denying a request for accommodation. Please **review my files and respond** to the listed questions to assist my school in undertaking that assessment. **Attach additional relevant written reports and test scores**. Thank you for your time and assistance.

COMPLETED BY HEALTH CARE PROVIDER

Qualifying professional must be an impartial individual who is not a family member of the student. He/she must be a medical doctor, licensed clinical social worker, or a licensed psychologist. He/she must be **qualified to diagnose under DSM/ICD guidelines** and have training and relevant expertise in the specific area of disability in which he/she is providing the diagnosis.

1. What is your **diagnosis** of my physical and/or mental health condition(s)?

OR

Comparing me to most people in the general population, please identify each major life activity or major bodily function that is **substantially limited** by my health condition(s). Please indicate how and to what extent each major life activity is limited. Specify the **functional limitations**. (**Quantify where possible**, ie. How far? How long? How much?)

_____

_____

_____

_____

2. Describe the **detrimental effects** of all the mitigating measures, e.g., medication, therapy, assistive devices, as they affect my participation in, or performance of the above identified **major life activities, compared to most people in the general population.**

_____

_____

_____

_____

3. How and to what extent does the disability limit my ability to perform learning tasks or functions required in a classroom/shop environment?

4. In your opinion, **what accommodations**, if any, will enable me to perform the essential functions of my education? Please indicate how your recommended accommodations will assist me in performing those essential functions.

VERIFICATION

Diagnosed by _____ Report Date _____

Address _____ City, State ZIP _____

Phone _____ Fax _____

I, the undersigned, affirm that I have provided the information above and that said information is true and correct to the best of my knowledge and belief.

Signature _____ Date _____

Please send the requested information by fax or mail to:
Holly Mickelson, ADA Coordinator, (Fax: 435-722-6999) 1100 East Lagoon Street, Roosevelt, Utah 84066
Trinity Long, ADA Coordinator, (Fax: 435-725-7199) 450 North 2000 West, Vernal, Utah 84078