# *Request for Accommodations*

## Mayo Clinic College of Medicine and Science

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Thank you for contacting the Office of Student Wellness and Success. To request accommodations at Mayo Clinic College of Medicine and Science (MCCMS), you must complete this Request for Accommodations form and submit documentation of your disability.

Review of your request for accommodations will begin when our office has received both your request form and disability documentation. The review process may take up to 3 weeks.

The Office of Student Wellness and Success welcomes the opportunity to meet with you to discuss your application, accommodations and campus climate as they relate to your specific program at any time. If you have any questions regarding the status of your request, or have additional information to provide, contact our office at mccms.ds@mayo.edu.

Submit your completed application and documentation by email to mccms.ds@mayo.edu. The information requested is necessary for funding and statistical purposes, and to assist in determination of accommodations. Information provided in this form will be kept confidential within our office. Files are securely stored and are not released to anyone other than our staff without the learner's explicit written permission.

## Demographic Information

| Learner Name *(First, Middle, Last)* | | Birth Date *(Month DD, YYYY)* | LAN ID (M number) (if applicable) | |
|---|---|---|---|---|
| Street Address | | City | State | ZIP Code |
| Phone | Email | | Date Today *(Month DD, YYYY)* | |
| How were you referred to the Office of Student Wellness and Success — Disability Services? | | | | |

## Academic Information

Specify your MCCMS school, program, and current year.

- ☐ Mayo Clinic School of Health Sciences — Program ______________________ Year __________
- ☐ Mayo Clinic School of Medicine Year __________
- ☐ Mayo Clinic Graduate School of Biomedical Sciences — Program ______________________ Year __________
- ☐ Mayo Clinic School of Graduate Medical Education — Program ______________________ Year __________
- ☐ If you are not yet registered at MCCMS, specify your MCCMS school, program, and anticipated start date.

  MCCMS school and program ______________________________________________

  Anticipated start date *(Month DD, YYYY)* ______________

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| Learner Name *(First, Middle, Last)* | LanID (M number) (if applicable) |
|---|---|
| | |

## Disability Information

**Functional Limitations**

Indicate the following by checking the appropriate box **without** consideration of mitigating measures (eg, medication). If the condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.

| **Major Life Activities** | **Negligible** | **Moderate** | **Substantial** | **Don't Know** |
|---|---|---|---|---|
| Self care | ☐ | ☐ | ☐ | ☐ |
| Manual tasks | ☐ | ☐ | ☐ | ☐ |
| Seeing | ☐ | ☐ | ☐ | ☐ |
| Hearing | ☐ | ☐ | ☐ | ☐ |
| Eating | ☐ | ☐ | ☐ | ☐ |
| Sleeping | ☐ | ☐ | ☐ | ☐ |
| Walking | ☐ | ☐ | ☐ | ☐ |
| Standing | ☐ | ☐ | ☐ | ☐ |
| Lifting | ☐ | ☐ | ☐ | ☐ |
| Bending | ☐ | ☐ | ☐ | ☐ |
| Speaking | ☐ | ☐ | ☐ | ☐ |
| Breathing | ☐ | ☐ | ☐ | ☐ |
| Learning | ☐ | ☐ | ☐ | ☐ |
| Reading | ☐ | ☐ | ☐ | ☐ |
| Concentrating | ☐ | ☐ | ☐ | ☐ |
| Thinking | ☐ | ☐ | ☐ | ☐ |
| Communicating | ☐ | ☐ | ☐ | ☐ |
| Working | ☐ | ☐ | ☐ | ☐ |

| Learner Name *(First, Middle, Last)* | LanID (M number) (if applicable) |
|---|---|
| | |

## Symptoms

Describe your symptoms, including side effects of treatment and medication, which may affect your academic performance.

Check the appropriate box to indicate the academic impact of the following.

| Activities | Negligible | Moderate | Substantial | Don't Know |
|---|---|---|---|---|
| Social interactions | ☐ | ☐ | ☐ | ☐ |
| Attendance | ☐ | ☐ | ☐ | ☐ |
| Keeping appointments | ☐ | ☐ | ☐ | ☐ |
| Meeting deadlines | ☐ | ☐ | ☐ | ☐ |
| Stress management | ☐ | ☐ | ☐ | ☐ |
| Managing internal distractions | ☐ | ☐ | ☐ | ☐ |
| Managing external distractions | ☐ | ☐ | ☐ | ☐ |
| Organization | ☐ | ☐ | ☐ | ☐ |
| Cognitive processing | ☐ | ☐ | ☐ | ☐ |
| Memory | ☐ | ☐ | ☐ | ☐ |
| Processing speed | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ |

Describe any situations or environmental conditions that might lead to an exacerbation of the condition.

## Other (if applicable)

☐ I believe I may have an undiagnosed learning disability, including ADHD, and am requesting a consultation with Disability Services.

☐ If this request is due to a temporary injury or condition, indicate the expected duration ______________________________

## History of Accommodations

If applicable, provide information about your history of receiving accommodations. Note that a history of accommodations, or lack thereof, does not necessarily guarantee or exclude provision of accommodations at MCCMS. If possible, provide a letter confirming your accommodations at previous institutions.

| Learner Name *(First, Middle, Last)* | LanID (M number) (if applicable) |
| --- | --- |
| | |

## Accommodations Request

| State any specific recommendations regarding academic accommodations and a rationale as to why these accommodations, adjustments, or services are warranted based upon your functional limitations. |
| --- |
| ☐ I'm not sure what I need — I'd like to discuss this with someone. |

I understand that it is my responsibility to provide disability documentation consistent with MCCMS practices for documentation in order to establish eligibility for services. I understand that review of my documentation is applicable only for providing services and accommodations at MCCMS may not be accepted by any other institution or agency.

| Learner Signature | Date *(Month DD, YYYY)* |
| --- | --- |
| | |