

Office of Student Services/Disability Support

1851 9th Street NW, 2nd Floor Washington DC 20001
202-238-2420 oss.disabilityservices@howard.edu



HOWARD
UNIVERSITY

STUDENT REQUEST FOR ACCOMMODATIONS FORM

In accordance with the Americans with Disabilities Act (ADA) of 1990, and Section 504 of the Rehabilitation Act of 1973, and other relevant federal, state and local disability and anti-discrimination laws Colleges and Universities are required to ensure equal access for all students. The services provided are to assist students with disabilities maximize their educations potential.

Current documentation supporting the disability and the requested accommodations, must be provided by a qualified diagnostician that includes a diagnosis, date of diagnosis, method used to arrive at the diagnosis, the credentials of the diagnosing professional, information regarding how the condition/ disability impacts a major life activity as well as the student's ability to participate in all activities offered by the institution.

“No otherwise qualified individual with a disability shall, solely by reason of their disability, be excluded from the participation in, be denied the benefits of, or be subjected to discriminations under any program or activity receiving Federal financial assistance” Section 504 of the Rehabilitation Act of 1973

A “qualified individual with a disability” is defined as one who meets the requisite academic and technical standards required for admission or participation in the postsecondary institution's programs and activities.

Please note students must formally request accommodations for each semester enrolled at Howard University. The accommodations and services provided are not retroactive.

First Time Requesting Accommodations at Howard Univ. _____ **Returning OSS Client** _____

Today's Date _____ Requesting Services for Semester: _____ Year: _____

Last Name _____ First Name _____ Middle Init _____

Date of Birth _____ Gender _____ Preferred Pronouns _____

Student ID Number @ _____ Social Security Number _____

Street Address _____

City _____ County _____ State _____ Zip Code _____

Primary Phone Number _____ Secondary Phone Number _____

Email Address: _____

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Armed Forces Status: Active Duty ____ Reserved ____ Retired ____
 Veteran ____ Dependent/Survivor ____ N/A ____
 Scholarship Recipient: Yes ____ No ____

Academic Advisors' Name: _____

Enrollment Status		
<input type="checkbox"/> Incoming Freshman	<input type="checkbox"/> Incoming Grad Student	<input type="checkbox"/> Incoming Prof Student
<input type="checkbox"/> Visiting Student	<input type="checkbox"/> Prospective Student	<input type="checkbox"/> Transfer Student
<input type="checkbox"/> Current Student	<input type="checkbox"/> Current Graduate Student	<input type="checkbox"/> Other
Level of Study		
Undergraduate	Graduate	Professional
<input type="checkbox"/> Freshman	<input type="checkbox"/> First Year	<input type="checkbox"/> First Year
<input type="checkbox"/> Sophomore	<input type="checkbox"/> Second Year	<input type="checkbox"/> Second Year
<input type="checkbox"/> Junior	<input type="checkbox"/> Third Year	<input type="checkbox"/> Third Year
<input type="checkbox"/> Senior	<input type="checkbox"/> Fourth Year	<input type="checkbox"/> Fourth Year
<input type="checkbox"/> Other	<input type="checkbox"/> Other	<input type="checkbox"/> Other
Professional School of Study		
<input type="checkbox"/> Arts & Sciences	<input type="checkbox"/> Business	<input type="checkbox"/> Communications
<input type="checkbox"/> Dentistry	<input type="checkbox"/> Divinity	<input type="checkbox"/> Education
<input type="checkbox"/> Engineering and Architecture	<input type="checkbox"/> Graduate School	<input type="checkbox"/> Law
<input type="checkbox"/> Medicine	<input type="checkbox"/> Nursing and Allied Health	<input type="checkbox"/> Pharmacy
<input type="checkbox"/> Social Work	<input type="checkbox"/> Other:	

DISABILITY INFORMATION: Check all documented disabilities that apply to you	
<input type="checkbox"/> ADD/ADHD Attention Deficit Disorder	<input type="checkbox"/> Low vision
<input type="checkbox"/> Autism Spectrum Disorder	<input type="checkbox"/> Medical Condition
<input type="checkbox"/> Blind	<input type="checkbox"/> Mobility Impairment
<input type="checkbox"/> Cancer	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Orthopedic Impairment
<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)
<input type="checkbox"/> Condition Requiring Medical Housing Accommodation*	<input type="checkbox"/> Psychiatric - Anxiety
<input type="checkbox"/> Deaf *	<input type="checkbox"/> Psychological Disabilities
<input type="checkbox"/> Epilepsy/Seizure Disorder	<input type="checkbox"/> Speech Impairment
<input type="checkbox"/> Food Related Medical Condition	<input type="checkbox"/> Temporary Condition
<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Other:

* Supplemental form required

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I am aware that if I need to request a new accommodation, I must provide updated documentation and schedule a meeting with the OSS, Disability Support office

I am aware that it is my responsibility to communicate directly with my faculty regarding exam accommodations and stay in communication about the time and place of such exams.

I am aware that it is my responsibility to contact the OSS/ Disability Support office if I am having any difficulties receiving my accommodations.

I am aware that notetaking assistance as an accommodation in any form are for my use only and may not be shared.

I am aware that notes provided by a notetaker will only be provided when I am present.

I am aware that approval of requested accommodation is dependent upon the documentation provided, the diagnosis of a disability, and the accommodation that is being requested.

I am aware that I may be eligible for temporary accommodations pending the request for additional documentation. Should this occur, I am responsible for providing the updated /additional documentation prior to requesting accommodations again.

I am aware that accommodations are not retroactive.

I am aware that accommodations may also be provided for a temporary disability.

I am aware that a request for an accommodation that creates a "fundamental alteration" or lowers the academic standards of a course will not be provided.

I am aware that the OSS is responsible for providing services for students with disabilities as per Howard University procedure, and as a result faculty are not required to provide any accommodations without a letter from the OSS

I am aware that to receive accommodations for exams and quizzes the faculty will need at least one-weeks' notice to coordinate and provide the accommodation.

By signing, I guarantee the information provided is correct to the best of my abilities, and hereby give permission to the Office of Student Services to release information to appropriate University personnel, to aid in the consideration and implementation of disability accommodations.

X Student Signature _____ Date _____
If Student is under 18 years of age
X Parent/Guardian Signature _____ Print Name _____

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OFFICE OF STUDENT SERVICES USE ONLY:

A meeting was held on (date & time) _____ and attended by:

_____	_____	_____	_____
Name	Relationship	Name	Relationship
_____	_____	_____	_____
Name	Relationship	Name	Relationship

This meeting was held: In person _____ By Telephone _____ Video Conference _____

Sources of Evaluation Information – Please check the documents/information relied on by team	
<input type="checkbox"/> Cognitive Assessments	<input type="checkbox"/> Social Emotional/Behavior Assessments
<input type="checkbox"/> Adaptive Behavior Assessments	<input type="checkbox"/> Health Medical Records
<input type="checkbox"/> Speech/and or language assessments	<input type="checkbox"/> Other – Note from doctor
<input type="checkbox"/> Occupational therapy assessments	<input type="checkbox"/> Other – Referral from UCS
<input type="checkbox"/> Hearing Assessments	<input type="checkbox"/> Vision Assessment
<input type="checkbox"/> Psychiatric Assessments	<input type="checkbox"/> Physical Therapy Assessments
<input type="checkbox"/> Student Report	

Documentation Was Appropriate: Yes ___ No ___ If No, list why:

Meeting Notes

Follow Up Needed/ Next Steps
