



Office of Accessibility Services

## Student Accessibility Services Accommodation Application

Please return the completed application to:

Zack Hulings, Director of Student Accessibility Services, Gwynedd Mercy  
University Address: 1325 Sunnyside Pike, P.O. Box 901, Gwynedd Valley, PA  
19437-0901 Email: [AccessibilityServices@gmercyu.edu](mailto:AccessibilityServices@gmercyu.edu)  
Phone: 215-646-7300 x21033

Date \_\_\_\_\_ Student Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Permanent Address \_\_\_\_\_ Campus Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

GMercyU email: \_\_\_\_\_ Email: \_\_\_\_\_

Program of study/major \_\_\_\_\_ Class Yr. \_\_\_\_\_

Undergraduate \_\_\_\_\_ Graduate \_\_\_\_\_ On-line \_\_\_\_\_ Accelerated Program \_\_\_\_\_

### I am requesting accommodations for:

Academics Only       Housing Only       Academics and Housing

due to (select all that apply):

Learning Disability       ADD/ADHD       Psychological Disability  
 Neurological Disability       Physical Disability

### Before application can be reviewed, the entire packet needs to be submitted in full. Packet checklist:

- Application (page 1) \_\_\_\_\_
- Student section (page 2) \_\_\_\_\_
- Release of information (page 3) \_\_\_\_\_
- Healthcare Professional Form (page 4 and 5) \_\_\_\_\_ \*Do Not Fill Out For Learning Disability
- Learning Disability requires psycho-educational evaluation (IEP is supplemental) \_\_\_\_\_



Office of Accessibility Services

## Student Section

**Please be aware the review, approval, and orientation process can take up to six weeks. It will benefit you to submit your application and documentation at least six to eight weeks before the start of your first course. If all documentation is not submitted, additional time may be needed.**

Please provide a brief description of your diagnosis/disability:

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List the accommodations you are requesting:

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List accommodations used in the past and note how helpful they were:

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If you are currently taking medication to help you with your disability, please state what medication you take, dosage, frequency, and how it helps you:

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Please provide information about other support services or strategies you utilize that are helpful to you (tutoring services, support groups, etc.):

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Please provide any additional information that should be considered regarding your request:

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Office of Accessibility Services

## Release of Information

In support of my request for reasonable accommodations, I have provided you with documentation of my condition. By signing this Authorization, I (please print name in space provided) \_\_\_\_\_ authorize you to release this information to those staff and faculty of Gwynedd Mercy University properly involved in evaluating and responding to my request for accommodation (for example: campus health, resident life, counseling services, etc.).

By signing this Authorization, I also give permission to the Director of Student Accessibility Services to discuss my condition and request for accommodation with those professionals who have evaluated or diagnosed the condition for which I am seeking accommodation and those with whom I am currently involved in medical/therapeutic support (for example: primary care physician, specialist physicians, psychiatrist, psychologist/counselor, tutor, etc.).

I understand that this authorization will remain in effect until (usually one year from the date signed) \_\_\_\_\_.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Director of Student  
Accessibility Services

\_\_\_\_\_  
Date



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## HEALTH CARE PROFESSIONAL FORM

**Those seeking accommodations for only a Learning Disability do not have to fill out this form.**

### Student's information

**Name:**

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**Address:**

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**Phone (home):**

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**Phone (cell):**

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### **INSTRUCTIONS – This form must be completed by a HEALTH CARE PROFESSIONAL**

The above-named student is requesting accommodations at Gwynedd Mercy University. In order to respond to the student's request, we require that you complete the information below. Please complete this information, attaching additional pages if necessary.

**Please note that this form must be completed prior to receipt of accommodations.**

Professional's Contact Information (Please Print):

**Physician's Stamp:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Telephone #: ( ) \_\_\_\_\_

Fax #: ( ) \_\_\_\_\_

License #: \_ \_ \_\_\_\_\_

Disability type (please check at least one):

Physical \_\_\_\_\_ Neurological \_\_\_\_\_ ADHD \_\_\_\_\_ Psychological \_\_\_\_\_



Office of Accessibility Services

**PRINT CLEARLY (if more space is needed, please use office letterhead)**

What is the student's relevant diagnosis/impairment (include diagnostic code)? How long has this student had this diagnosis?

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Is this student currently being treated for this diagnosis?  Yes  NO

Is the impairment expected to last six months or longer?  Yes  NO

Describe the present symptoms, their frequency and severity, and how the disability interferes with one or more major life activities.

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What treatment and/or medication(s) is the student undergoing? Please list medications and dosages.

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Do you expect these symptoms to continue for the foreseeable future?  Yes  No

If no, when do you expect the symptoms to abate?

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How will the student be able to manage these symptoms in other campus environments (e.g. classrooms, dining hall, library)?

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What specific symptoms does the student have that, in your judgment, **prohibit** the student from being able to live safely in a standard on-campus residence hall.

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For episodic conditions, how frequent are the episodes, and what is their duration and severity?



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What accommodations are reasonable and appropriate (i.e. to maintain general wellness) for a college student?

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Are there other effective means that would achieve similar benefits as the requested accommodation?

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Is the impact of the condition life threatening if the request is not met? \_\_\_ Yes \_\_\_ No

\_\_\_ I have attached the documentation with the results of evaluations which led to this diagnosis.

Professional's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name: \_\_\_\_\_

**Please return the completed form to:**  
**Zack Hulings, Director of Student Accessibility Services**  
**Gwynedd Mercy University**  
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**Gwynedd Valley, PA 19437-0901**  
**Email: [AccessibilityServices@gmercyu.edu](mailto:AccessibilityServices@gmercyu.edu)**  
**Phone: 215-646-7300 x21033**

For Administration Only			
Health & Wellness Director	_____ approved	_____ not approved	Reason: _____
Director of Accessibility Services	_____ approved	_____ not approved	Reason: _____