DIVISION OF STUDENT AFFAIRS
ACCESSIBILITY AND DISABILITY SERVICE

Accessibility & Disability Service
4281 Chapel Lane
College Park, MD 20742-811
(301) 314-7682 | adsfrontdesk@umd.edu

Student Workplace Accommodation Request

STATEMENT OF UNDERSTANDING (to be completed by student)

1. I understand that the establishment of disability accommodation(s) is an interactive process and my failure to participate within these collaborative conversions may delay the completion of this process.
2. I understand that I should request a detailed listing of the essential duties of my job from my supervisor in order to engage in the interactive process to help determine accommodation(s).
3. I understand the importance of providing my healthcare provider with a detailed list of my job's essential duties. This helps them accurately describe how my disability may impact my ability to complete essential requirements.

Student Signature _____ Date _____

**I authorize the University of Maryland to receive information from the provider listed above. I also authorize my provider to discuss my disability/s with the appropriate University personnel to make a proper determination of necessary accommodations. My signature also indicates that the appropriate healthcare provider or their designee has completed the statements and documentation. I understand that providing false information places me in violation of the University of Maryland's Student Code of Conduct and subjects me to any applicable sanctions.*

ACCOMMODATIONS REQUEST DETAILS (to be completed by student)

Student Name: _____
UID: _____
Email: _____
Phone: _____
Department: _____
Position / Title: _____
Supervisor: _____
Supervisor Email/Phone: _____

1. Please describe the disability for which you are requesting a student workplace accommodation.

_____
_____
_____
_____

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2. Please describe in detail how your disability affects your ability to perform the essential duties of your job.

3. Please describe the accommodation(s) you're seeking and how they might assist you in carrying out your job responsibilities effectively.

Purpose of this Form

At the University of Maryland College Park, Accessibility and Disability Service (ADS) coordinates the provision of accommodations for students with diagnosed disabilities to ensure equal access and opportunity to educational programs and activities.

Documentation can aid us in the process of determining if a diagnosed condition meets the legal definition of a disability covered under Section 504 of the Rehabilitation Act (1973) and the Americans with Disabilities Act as amended in 2008. These laws define a disability as a physical or mental impairment that substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks. Understanding of the functional limitations of the condition can help us determine appropriate reasonable accommodations for a student in their employment setting.

The information provided will be kept in the student's file at ADS, where it will be held securely and confidentially. This form may be released to the student at their request.

Please note: Documentation must come from a licensed or credentialed provider or evaluator, whose certification or expertise is relevant to the disability or diagnosed condition.

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How to Submit
Once this form has been completed it should be submitted to ADS. The student can upload this form with their application in the ADS Online Portal or it can be turned into ADS directly by the student or healthcare provider via the contact information below:

Accessibility and Disability Service
University of Maryland College Park
Shoemaker Building, 4281 Chapel Lane
College Park, MD 20742-811

Phone: 301-314-7682
Fax: (301) 405-0813
Email: adsfrontdesk@umd.edu

Health Care Provider Information:

To be completed by a licensed and/or certified professional who is an impartial evaluator and not a family member or in a dual relationship with the student.

Student's Name: _____ **DOB:** _____

Date student was first seen: _____ **Date student was last seen:** _____

How often do you see this student? _____

Provider Name (print) _____

Credentials and State License or Certification #: _____

Provider Signature _____ **Date** _____

By signing below I am verifying that the diagnosis(es) and supporting information provided is accurate and that I am a qualified professional who is licensed and properly credentialed to diagnose and treat the stated conditions.

Address:_____

Phone Number: _____ **Email:** _____

Instructions
Please legibly and thoroughly complete this form. The more details provided, the better we can help the student. Inadequate information, incomplete answers, and/or illegible handwriting will delay the eligibility review process by necessitating follow up contact for clarification.

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Section 1: Verification of Disability

The Americans with Disabilities Act (ADA) and the ADA Amendments Act of 2008 define disability as a physical or mental impairment that substantially limits one or more major life activities and has an expected duration of not less than 6-8 weeks.

Please note that a diagnosis alone does not automatically qualify a student for accommodations. The information on this form should identify a disability, describe its current impact and address how the impairment substantially limits a major life activity.

1. Is the student's condition, as they currently experience it, classified as a disability?
   □ No □ Yes (If no, there is no need to continue further with this form)
2. Diagnosis(es) _____
3. Please describe the current symptoms of the condition, including the frequency, severity, and pervasiveness of these impacts?

_____
_____
_____
_____

   a. If the student has episodic flare-ups, please also detail the triggers and the typical frequency and duration of these episodes.

_____
_____
_____
_____

4. Please describe how the limitations impact the essential duties of the job based on the description provided by the student?

_____
_____
_____
_____

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5. Have there been any significant life events that have impacted the student's ability to work and/or complete major life activities in the past 12 months? ☐ No ☐ Yes (If yes, please explain)

_____
_____
_____
_____

Section 2: Expected Duration of Condition

☐ Permanent, continuous: Symptoms and functional limitations are expected to endure throughout their academic tenure with little likelihood of change.

☐ Permanent, episodic: Cycles of wellness interrupted by episodes of sickness or impairment throughout their academic tenure.

☐ Temporary, Functional limitations are temporary, or the severity may change, and should be reassessed by: _____/_____/_____

☐ Provisional: I am still monitoring/assessing the student. Assessment likely to be completed by: _____/_____/_____

Section 3: Current Treatment

1. (Select): ☐ Individual/Group Therapy ☐ Physical Therapy ☐ Occupational Therapy

   ☐ Medication Management Other: _____
2. Is the student currently taking medications?
   a. ☐ Yes ☐ No ☐ N/A – not prescribing physician
      i. If yes, please describe how the medication impacts the student's ability to complete job duties or in daily living activities.

_____
_____
_____
_____