DES MOINES UNIVERSITY
MEDICINE & HEALTH SCIENCES

Center for Educational Enhancement

3200 Grand Avenue • Des Moines, Iowa 50312-4198 • 515-271-4452 • accommodations@dmu.edu

Temporary Medical Accommodations Form

Name: _____ Date Received: _____

All information you provide as part of your accommodations application is held confidentially and disclosed on a *need to know* basis only to individuals involved in making accommodations decisions for you in compliance with the Family Educational Rights and Privacy Act (FERPA). **This form, and all accompanying documentation, should be submitted electronically. Please contact the CEE at cee@dmu.edu if there is a concern with obtaining an electronic copy of this form.**

Note: Accommodations are intended to reduce the impact of functional limitations for students; how a temporary condition impacts a particular student can be unique to that student. Therefore, evidence of a specific functional limitation(s) documented by your physician is necessary prior to accommodations being granted on a case by case basis.

PART 1: CONTACT INFORMATION

Background Information

Street Address: _____ City/State: _____

E-mail: _____ Phone: _____

Gender: ☐ Female ☐ Male ☐ Prefer Not to Disclose

Primary Language: _____ Other Language(s): _____

Program of Study: _____

Current course load (Credit Hours): _____ Anticipated graduation year: _____

Current academic standing: ☐ Year 1 ☐ Year 2 ☐ Year 3 ☐ Year 4 ☐ Other: _____

Emergency contacts

List of person(s) to be contacted in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

PART 2: SYMPTOMS

How did you find out about this office? If referred, please indicate who referred you.

What temporary accommodation(s) are you requesting?

Describe the nature of the temporary medical illness or condition:

Do you have **documentation** of your condition? (Required prior to review of application)

☐ Yes, documentation is submitted
☐ Yes, planning to submit the documentation
☐ No (explain): _____

Expected date of recovery: _____

PART 3: IMPACT

Describe how your temporary limitations impact your learning and testing? Be as specific as possible.

Explain how the requested accommodations help compensate for the functional limitations you experience as a result of your temporary condition.

Describe any special training, services, or medication you have received for your limitation.

What compensatory learning or coping strategies do you use to assist you in mitigating the impact of your limitation?

Provide a personal statement describing your impairment and its impact on your daily life and educational functioning. (Use as much space as you need or attach additional pages.)

I understand the provided information will assist the Accommodations and Educational Support Specialist in determining the most effective accommodations and/or compensatory strategies for my use. I authorize the Accommodations and Educational Support Specialist in CEE to contact the professional(s) who diagnosed the condition if necessary, for further information. I authorize such professional(s) and entities to communicate with Des Moines University in this regard and to provide Des Moines University with such clarification and/or additional information.

Signature: _____ Date: _____

Please return this form and supporting documentation to: Accommodations Specialist, Center for Educational Enhancement, Des Moines University, 3200 Grand Ave, Des Moines, IA 50312