ACADEMIC ACCOMMODATION REQUEST FORM
FOR STUDENTS WITH ACCESSIBILITY NEEDS

Please refer to the Accessibility Services information on Russell Sage College’s website for the complete process for requesting disability-related academic accommodations at Russell Sage College. Students must follow these procedures and provide all of the required information in order to be considered for academic accommodations.

Requests for academic accommodations should be made prior to the start of each semester, unless circumstances change after the start of the semester.

Requests cannot be considered until both parts of the attached form have been received by the Office of Accessibility Services. Upon receipt of both parts of the Academic Accommodations Request Form, the Director of Accessibility Services will review the provided information and documentation and determine if the student meets the criteria for accommodation. Then, the student will be notified of this decision and/or may be asked to provide additional documentation. If the Director of Accessibility Services reviews the request and approves it based on the documentation provided, then an accommodations letter will be developed for student review and approval, followed by distribution of the accommodations letter to each faculty member that the student has designated.

Please contact the Office of Accessibility Services with any questions.

Director of Accessibility Services
accessibility_services@sage.edu
Fax: 518-292-8621
Albany Campus: 3rd Floor Library | 518-292-8624
Troy Campus: 3rd Floor, Shea Learning Center | 518-244-6874
Name: ___________________________ Date: ____________

Permanent Address: ____________________________________________________________

Email: __________________________________________ Phone: _______________________

Current Academic Status:

□ First Year    □ Sophomore    □ Junior    □ Senior    □ Graduate Student

Please indicate your specific disability that prompts you to seek academic accommodations.

_____________________________________________________________________________________________________________________

If this request is due to a temporary condition, please indicate expected duration. ___________

Which academic accommodation(s) are you requesting? (Check all that apply.)

□ Alternate formats for printed material (please specify) ________________________________

□ Assistive technology (please specify) ____________________________________________

□ Note taking assistance

□ Sign language interpreter

□ Other auxiliary aids* (please specify) ____________________________________________

□ Reduced course load

□ Extended time on papers

□ Test accommodations (please specify) ____________________________________________

Please specify (Time and half or double the amount of time)

*Please note that Russell Sage College is not required to provide a 1:1 attendant or tutor, any
individually prescribed device, or any services of a personal nature.

If you would like, you may also attach: (1) a personal statement describing your condition and your
need for each of the accommodations that you are requesting; or (2) any secondary school final
individualized education plan (IEP), “Section 504 plan” or special education “exit summary” that
you may have received during your final year in secondary school. This is optional and is not
required for approval of academic accommodations.
Please have a qualified medical or other licensed health care provider complete PART II of this application. Applications cannot be considered until both parts are received. By signing below you certify that the information you have provided is accurate and true, to the best of your knowledge.

Signature: ________________________________  Date: _____
To the Student: THIS FORM MUST BE FILLED OUT IN ITS ENTIRETY BY YOUR TREATING HEALTH CARE PROVIDER. If this form is completed by anyone other than an appropriate and qualified licensed healthcare professional, the information provided may not be used to support your accommodation request and Russell Sage College reserves the right to request additional documentation. Since a request for additional information can result in a delay in your request for accommodations, you are strongly urged to have the form completed by an appropriate and qualified licensed health care professional who will include all requested information.

To the Evaluator: The student named below has represented that they have a disability which will require academic accommodation at Russell Sage College. The information you provide will be used to determine the appropriateness of the requested accommodation(s). Please take the time to complete this form and thoroughly answer all questions. We must receive an original form with your signature. We cannot accept substitutions for this. Please contact us with any questions. All information provided to us is confidential. With the student’s permission, we may contact you directly for additional information to assist us in making a determination.

Please contact the Office of Accessibility Services with any questions.

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Student Name: ________________________________

Which academic accommodation(s) are you requesting? (Check all that apply.)

☐ Alternate formats for printed material (please specify) ________________________________

☐ Assistive technology (please specify) _______________________________________________

☐ Note taking assistance ☐ Sign language interpreter

☐ Other auxiliary aids* (please specify) _______________________________________________

☐ Reduced course load

☐ Test accommodations (please specify) (time and half or double the amount of time)

*Please note that Russell Sage is not required to provide a 1:1 attendant or tutor, any individually prescribed device, or any services of a personal nature.
1. Please identify the physical or mental impairment for which you are treating the student:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

2. Please list date of onset and severity: ____________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

3. How long have you been treating the student? _______________________________________

____________________________________________________________________________________

4. When was the last date of treatment you had with the student? _________________________

____________________________________________________________________________________

5. Please list any current functional limitations and educational impact:

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________
6. For each and every academic accommodation requested above, please describe why the requested accommodation is necessary:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Healthcare Professional Name: ____________________________________________

Professional Licensure: ___________________________ State: ____ Number: ______

Signature: ___________________________________________ Date: ________________

Office Address: ________________________________ Phone: ___________________