American University of the Caribbean
School of Medicine

Request for Reasonable Accommodation

Students requesting accommodation must be able to meet AUC technical standards with accommodations that can reasonably be provided in all required settings. The technical standards may be found in the Student Handbook. Although AUC is committed to providing reasonable accommodations to qualifying students, AUC cannot guarantee any student will obtain any or similar accommodations from any clinical facility or the USMLE. Please refer to the Student Handbook for the full section on Accommodations of Students with Disabilities.

Students seeking disability accommodations must complete all sections of this form. Parts 1-3 must be completed before AUC can consider your request for disability accommodations.

Return this completed, signed form along with supporting documentation (Include test results or evaluations completed within the past 5 years) to the Dr. Rinker, Assistant Dean of Student Affairs.
Fax: (721) 545 2262 Phone: (721) 545 2298 Email: srinker@aucmed.edu

PART I: Personal Information (to be completed by student)

Name: _____

Today's Date: _____ Program Start date: _____

Check only one:_____Applicant_____First Semester Student_____Continuing Student

Admissions Representative (if checked applicant above): _____

Permanent Address: _____

City:_____State:_____Zip Code: _____

St. Maarten Address (if available): _____

Phone number:_____Secondary phone number: _____

Email Address (other than AUC address):_____

PART II: Impairment Information (to be completed by student)

A. The nature of my impairment is:

___Auditory
___Visual
___Physical

___Learning
___Psychiatric

B. This impairment is (check only one)

___Permanent

___Temporary

C. Please describe your impairment and explain the effect your impairment has on your ability to succeed in a postsecondary educational setting. Include the age of onset of the impairment, and refer to diagnostic codes if known. (Use an additional page if necessary.)

D. List the specific accommodations that you are requesting.

PART III: Certification and Documentation
(Sections A, B, and C must to be completed, signed, and dated by student)

A. Statement of Request

I,_____, am providing clinical/medical documentation of my impairment. I hereby recognize that only original documentation completed/provided by certified or licensed professionals will be accepted to support my accommodation request.

Student Signature:_____Date: _____

B: Statement of Medical Release

I,_____, authorize_____(Health Care provider) to release my personal health information to AUC. I further authorize AUC to contact my healthcare provider for further information, and/or to use and disclose my information as necessary to consider my request for accommodation and to implement any approved accommodations.

Student Signature:_____Date: _____

C: Statement of Certification

I,_____, authorize_____(Health Care provider) to certify my impairment by completing the information in Section D below.

Student Signature:_____Date: _____

D. Statement of Authentication (to be completed by healthcare professional)

The individual listed on the previous page has registered for support services with AUC. Please provide the following, use additional pages if necessary:

(a) A diagnosis and supporting documentation (as an addendum) to support this individual's impairment, including test results or evaluations completed within the past 5 years.

b) A description of how this individual's impairment includes functional limitations as they relate to medical education courses of study.

(c) A recommendation of specific accommodations that might be appropriate for this individual in an educational setting

Name:_____ Title:_____

Agency/ Hospital/Practice: _____

Phone number:_____ Fax number: _____

Address: _____

City:_____State:_____Zip Code : _____

Signature:_____ Date: _____

For AUC internal use only

Accommodation(s) approved:

Accommodation(s) not approved:

Assistant Dean of Student Affairs:_____ Date: _____