



REQUEST FOR SUPPLEMENTAL ACCOMMODATIONS & SERVICES

Please allow at least two weeks for The Office Disability Services (ODS) to review your application and supporting documentation. Please note that your application cannot be reviewed until documentation is received. Documentation Guidelines and a Disability Verification Form (used in lieu of physician writing a letter) are available in the ODS Office and online. Please also note that a separate application and guidelines are available for housing accommodations on the ODS Website, www.health.columbia.edu. After ODS has reviewed your application, you will be contacted via e-mail with information about the status of your application. Please contact ODS if you have questions regarding the ODS registration process.

Name: _____

Today's date: _____

UNI: _____

School: _____

Columbia E-mail Address: _____

Phone #: _____

Please check all of the additional accommodations that you are requesting:

- Testing Accommodations
 - Extended time for testing:
 - Amount Requested: _____
 - Smaller proctored environment
 - Reader for exams
 - Scribe for exams (answer recorded or written for student)
 - Use of computer for exams
 - Use of spell-check device for exams (when appropriate)
 - Use of calculator for exams (when appropriate)
- Classroom Accommodations
 - Note-taking services
 - Class notes and other materials in an alternate format
 - Please specify: _____
 - Permission to tape record lectures/classes
 - Preferential classroom seating
 - Accessible classroom and furniture
- Communication Accommodations
 - Sign-language interpreters
 - Assistive listening devices
 - Speech-to-text Services

- Other Accommodations
 - Assistive technology
 - Please specify: _____
 - Textbooks in an alternate format
 - Course substitution
 - Please specify: _____
 - Elevator and lift access
 - Other Accommodation(s)
 - Please specify: _____

Please indicate why you are requesting the above accommodations. Check all that apply:

- Acquired new disability (Additional documentation required)

Please indicate your disability type(s). Check all that apply

 - Learning Disability
 - AD/HD
 - Chronic Medical Condition
 - Physical Disability (mobility impairment)
 - Psychiatric Disability (psychological or mental illness)
 - Visual Impairment or Blindness
 - Deaf or Hard-of-Hearing
 - Substance Abuse (Recovery)
 - Traumatic Brain Injury
 - Temporary Injury
 - Please describe: _____
 - Other
 - Please describe: _____

- Change in current disability's status

Please describe: _____

- Change in medication status (Additional documentation required)

Please indicate new medication(s) taken and/or new dosage: _____

Please list any side-effects and their impact on your cognitive abilities: _____

Other: _____
