ADA: REQUEST FOR REASONABLE ACCOMMODATION

This form is to be completed by the Physician

The Americans with Disabilities Act (ADA) gives individuals with disabilities civil rights protection that is similar to that provided to all individuals based on race, sex, national origin, and religion. The act guarantees equal opportunity in employment, public accommodations, transportation, state and local government services, and telecommunications. In addition, Section 504 of the 1973 Rehabilitation act states: "No otherwise qualified handicapped individual in the United States shall, solely based on his/her handicap, be denied benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance".

Hawaii Medical College understands that a disability may preclude a student from completing the required course competencies and or from fulfilling the course requirements in the same method expected of nondisabled students. In compliance with Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990, qualified applicants/ students with disabilities may request that appropriate course accommodations be considered. All applicants/students with special needs are encouraged to apply.

Required request components:

- Appropriate Note/ Documentation

This section to be completed by Student:

Student Name:_____ **Program:** _____

Student Email: _____ **Phone #:** _____

This section is to be completed by the physician:

Nature of the qualifying disability *(Please describe the nature, extent, and duration of the disability):*

_____

_____

_____

_____

_____

Requested/Suggested accommodation: *(Please describe the accommodations you believe are needed to enable the individual to perform the essential functions in the class.)*

_____

_____

_____

_____

_____

ADA: REQUEST FOR REASONABLE ACCOMMODATION

This form is to be completed by the Physician

Physician Contact information:

Name of Physician: _____

Address: _____

_____

Telephone: _____

Fax number: _____

The physician may receive a letter/fax from Hawaii Medical College requesting information on your impairment/disability and recommendations for accommodations.

With my signature, I hereby authorize the Education Department to review any pertinent records. I authorize the release of necessary confidential medical information regarding my disability to Hawaii Medical College. I also affirm that to the best of my knowledge, the information provided on this form and the information attached (if applicable) accurately reflects the facts involved in this case.

_____

Physician Signature Date

Student Signature Date

_____

Completed requests should be turned into the Assistant /Director of Education. Requests will be reviewed for accuracy and completed by the Education Department upon receipt. Incomplete or inaccurate requests will be returned to student or admissions advisor along with additional instructions for completion. Submission of the request does not constitute guarantee of approval.

Any special circumstances will be decided upon by the Assistant/Director of Education. Student and advisor will be notified of the decision as soon as possible.

Please contact the Assistant Director / Director of Education if you have any questions or need an assistance preparing your request.

_____

☐ Approved ☐ Disapproved

Comments/Reason for Disapproval:

_____

_____

Director of Education Signature Date

_____