SAS APPLICATION FOR STUDENT ACCOMMODATIONS

Term __________ Program __________ DeVry Home Location ________________

This application is valid only after the student is admitted to DeVry University.

PERSONAL INFORMATION

DeVry Student Number: Birth Date:

Name: (please print last name, first name)

Local Address:

Permanent Address:

Local Phone: Permanent Phone:

EDUCATIONAL INFORMATION

High School:

City/State: Year of Graduation:

Special Education Resource Classes:

Previous College/University:

Acceptable documentation must be received 60 days before special accommodations can/may be provided.

FOR OFFICE USE ONLY

ADMISSION DATE & VERIFICATION

DOCUMENTATION OF DISABILITY Year of Diagnosis:

Nature of Disability:

Name & Title of Professional Making a Diagnosis:

Address:

Criteria Used for Diagnosis: Telephone:

Suggested Accommodations:

For further information, call 630-652-8364; for TTY, call 630-953-2551
SAS
STUDENT ACCESSIBILITY REQUEST FORM
I am requesting the following services

STUDENT SERVICES:

Physical Accommodations:
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

ACADEMIC SERVICES:

Instructional Accommodations:
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________
____________________________________________________

I understand that it is my responsibility to inform Student Services and/or the Academic Support Center regarding my enrollment for EACH TERM. This must be done as soon as I register, so that my services may be arranged. Specific accommodations will be arranged, if possible, by the SAS Council only after the student completes an application, presents appropriate documentation, and meets with a council member.

STUDENT NAME (PRINTED)   STUDENT NUMBER
____________________________________  _________________________
STUDENT SIGNATURE            DATE
SAS
INFORMATION RELEASE FORM
SPECIAL ACCOMMODATIONS
DeVRY UNIVERSITY Chicago

I, the undersigned, give permission to DeVry University Student Services and/or Academic Support Center to receive full medical, educational, or other pertinent information from appropriate professional agencies or sources.

I also give my consent to Student Services and/or the Academic Support Center to provide information to other appropriate professional agencies or sources.

I absolve DeVry University from any legal liability which may arise from the release of this information.

I give DeVry University Student Services and/or Academic Support Center permission to provide appropriate educational information to DeVry University instructors, Academic deans, and Student Services staff, and appropriate institutional staff to assist in providing services.

____________________________________________________________________________________
STUDENT SIGNATURE   DATE   STUDENT NUMBER
____________________________________________________________________________________

I understand that it is my responsibility to acquire and submit appropriate documentation of my disability and to inform the office of Student Services and/or Academic Support Center regarding enrollment for EACH TERM. This needs to be done as soon as I register, so that appropriate accommodations may be arranged for the next term. Sixty days is necessary to arrange accommodations.

____________________________________________________________________________________
STUDENT SIGNATURE   DATE   STUDENT NUMBER

Reproduction of this form will be considered equal to the original form.
The following student has requested accommodations under the Americans with Disabilities Act (ADA). Please provide the information requested below so we can determine reasonable accommodations for this student.

Name ________________________________________________________________

Medical Condition (including level of severity and current medications)
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Date of Diagnosis ______________________________________________________

Describe the functional limitations of this condition. In particular, how does this condition affect the student’s performance in and/or attendance at school? What physical and/or academic accommodations would you recommend for this student?
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Signature of Licensed Physician ________________________________ Date ______

Printed Name and Title __________________________________________________

Address
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

Thank you for your cooperation.

Joe Onorio
ADA Coordinator