

**Request for Accommodations Form (RAF)**

The Mount Carmel College of Nursing Accommodations Coordinator is responsible for evaluating requests for academic and/or non-academic adjustments or accommodations from qualified students with disabilities enrolled in College programs. Contact information for the Coordinator is listed below:

Student Accessibility Services

Attn: Accommodations Coordinator Phone: 614-234-2341

Mount Carmel College of Nursing Fax: 614-234-5979

127 S. Davis Ave. Email: accessibility@mccn.edu   
Columbus, OH 43222

Students requesting academic and/or non-academic accommodations and/or adjustments should complete this form and then contact the Coordinator (using the information above) to schedule an appointment. During the appointment, the Coordinator will discuss options with the student and evaluate any existing documentation which supports the student’s requests.

Students without sufficient recent documentation from a qualified healthcare provider are required to submit a completed Healthcare Provider Form to the Coordinator (or have the form completed and sent directly from the Healthcare Provider evaluating the student). Students are encouraged to review the College’s policy on Disability and Accommodations Policy and Procedure for more detailed information on the necessary procedures.

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| **STUDENT INFORMATION**  **(MCCN Student to Complete this Section)** | | |
| Name (Last, First, Middle Initial) | | Phone (with area code)  □ Cell □ Home □ Work |
| Student ID Number | Date of Birth | Student Information:  □ Main □ Fairfield □ Online  □ BSN □ SDAP □ RN-BSN □ MS □ DNP |

1. What is the nature of your disability? (check all that apply)

□ Hearing □ Physical/Medical □ LD/ADD/ADHD/Psych □ Visual □ Temporary

2. Have you previously received accommodations or adjustments while enrolled at Mount Carmel College of Nursing?

□ Yes □ No If yes, what semesters and years?

3. For which semesters are you requesting adjustments or accommodations?

(Approved accommodations are valid for up to one year and require re-evaluation and renewal each year.)

□ Spring 2020 □ Summer Session 2020 □ Fall 2020

4. Please describe the accommodations or adjustments you are requesting:

*By signing below, I certify that the information on this form is true and correct to the best of my knowledge. I understand that Mount*

*Carmel College of Nursing requires documentation of my disability to support this request.*

Student Signature:

Date:

Form Date: 1/2020 Page **1** of **1**