



TOURO UNIVERSITY
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APPLICATION FOR ACCOMMODATIONS & SERVICES

Please allow **at least two weeks** for Student Affairs (SA) to review your application and supporting documentation. **Please note that your application cannot be reviewed until documentation is received.** General Documentation Guidelines are outlined below. After SA has reviewed your application, you will be contacted via e-mail or by phone so that we may engage you in an interactive dialogue relative to your application. Please contact SA if you have questions regarding the SA registration process.

Section I: Student Information

Name: _____ Today's Date: _____

Student ID Number: _____ Date of Birth: _____

Gender: _____

Permanent Address: _____
(Street & Apt. #)

(City) (State) (Zip)

Local Address: _____
(Street & Apt #) (City) (Zip)

Phone # (Cell): _____

Phone # (Permanent): _____

Touro E-mail Address (If Available): _____

Other E-mail Address: _____

Section II: Programmatic Information

Touro University California, College you are attending: _____)

Program: _____

Anticipated Graduation Date: _____ First Semester at Touro: _____

Please briefly describe your program. Be sure to include information about fieldwork, classroom, clinical or laboratory components, comprehensive examinations, a thesis/dissertation, or other requirements that may be impacted by your disability or may need reasonable accommodations:

Section III: Disability Related Information

Please answer the following questions regarding your disability and how it impacts your ability to learn, attend, or participate in University life.

1. Please indicate your disability category(ies). Check all that apply:

- Learning Disability
- Attention Deficit/Hyperactivity Disorder (ADHD)
- 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/Condition
- Undiagnosed Condition

➤ Please describe: _____

Other

➤ Please specify: _____

2. Specify the diagnosis or type of disability based on the category above:

3. Please identify what major life activity(ies) is(are) affected by your condition(s):

4. What mitigating measures have you used to address your condition(s). Mitigating measures are any device, treatment or medication, assistive technology, reasonable accommodations, and/or compensatory strategies that reduce the impact of a disability.

5. Please check all that apply:

- I use a wheelchair.
- I use assistive mobility devices (braces, crutches, cane, or prosthesis).
- I wear a hearing aid.
- I need to read lips of instructors.
- I have difficulty reading the blackboard.
- I have difficulty taking notes in class.
- I have difficulty writing.
- I have difficulty standing for long periods of time.
- I tire easily when I walk distances.
- I have difficulty walking up/down stairs.
- Please describe any other mobility or disability related difficulties you are currently experiencing:

6. Are you currently taking any medication related to your disability or medical condition?

- Yes No (check only one)

If yes, list all of the medications you are taking: _____

If yes, please also list any side-effects of the medications that you are taking and their positive and negative impact on your academic/cognitive abilities and/or other activities: _____

7. Please check all of the reasonable accommodations that you are requesting:

- Testing Accommodations
 - Please specify: _____
- Classroom Accommodations
 - Please specify: _____
- Communication Accommodations
 - Please specify: _____
- Other Accommodations
 - Please specify: _____

8. Briefly describe why you are requesting the above accommodations:

9. Please list any services/accommodations you received as an undergraduate or at any previously attended school: (Please note that while such services do not necessarily carry over to your current program, the information is helpful to give SA background information on your disability-related needs.)

Institution: _____ Years Attended: _____

Accommodation(s) Received: _____

Institution: _____ Years Attended: _____

Accommodation(s) Received: _____

Section IV: Referral Information

Please indicate how you heard about Touro University disability accommodation services:

- | | |
|--|--|
| <input type="checkbox"/> Registrar | <input type="checkbox"/> Friend or Family Member |
| <input type="checkbox"/> Academic Advisor/Dean | <input type="checkbox"/> Primary Care Provider |
| <input type="checkbox"/> Admissions | <input type="checkbox"/> Professor/ TA |
| <input type="checkbox"/> Touro Website | <input type="checkbox"/> Other: specify: _____ |
| <input type="checkbox"/> Self | |

Section V: Agency Information

Do you receive services from any of the following agencies?

- Vocational Rehabilitation Services
 - Specify State and Agency: _____
- Veterans Administration (VA)
- Other: _____

If yes, please provide the following information:

Counselor's name: _____

Office Address or Location: _____

Services currently receiving from Agency: _____

Section VI: Professional Assessment of Mitigating Measures

In comparison with the average person in the general population, please have your medical or other licensed professional rate how your major life activity(ies) is(are) affected by your condition(s) both with and without mitigating measures:

With Mitigating Measures

- Mild
- Moderate
- Substantial
- Severe

Without Mitigating Measures

- Mild
- Moderate
- Substantial
- Severe

Print Name of licensed professional providing this rating

Professional's Signature

Date

I, _____, give Touro University California permission to explore coverage and reasonable accommodations under the Americans with Disabilities Act of 1990, Section 504 of Rehabilitation Act, and all applicable State and Federal laws. I understand that all information obtained during this process will be maintained and used in accordance with the ADA, including its confidentiality requirements. I certify that I have read and reviewed the description of the program and have been informed of the essential requirements. I further certify that the foregoing statements are complete, accurate, and true to the best of my knowledge, and I understand that Touro University California may require me to undergo testing or evaluation by medical personnel retained by Touro University California for the purpose of establishing the existence and extent of my disability, illness, condition, or disease and my ability to meet essential academic functions and requirements with or without reasonable accommodation.

Signature of Requestor/Student*

Date

*Important Notes:

Reasonable accommodations cannot be applied retroactively.

Provision of reasonable accommodations during our program is not a guarantee of successful graduation, licensure, certification or continued certification. Students must successfully satisfy program requirements and meet the program's rigors. Testing providers and licensing and certification agencies, boards and organizations have their own reasonable accommodation requirements. Reasonable accommodations, if any, received by the student at Touro University are not binding on those providers, agencies, boards or organizations. The student is solely responsible to investigate, apply for and acquire accommodations with any necessary providers, agencies, boards or organizations. Touro University hereby expressly disclaims any liability in such event those providers, agencies, boards or organizations do not grant the student accommodations - such risk is borne exclusively by student.



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Medical Records Review Acknowledgement, Waiver and Consent

I, _____ (student), give Touro University California permission to contact _____ (health care provider) and have executed a Authorization to Release of Health Information.

I understand the reason for this contact is to advise Touro University California about my educational needs and functional abilities and limitations in relation to my educational goals and functions. I understand that the University may provide _____ (health care provider) with specific information about the program if requested, including the essential functions and specific requirements. I authorize Touro University to discuss the program and my participation in it, including sharing my education record.

I understand that Touro University may use experts or outside reviewers to review my records, I hereby consent to such additional disclosure. My Authorization to Release of Health Information shall be read to include these additional disclosures, if any.

Student Signature

Date

Witness

Date



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**AUTHORIZATION FOR USE OR DISCLOSURE
OF HEALTH INFORMATION TO TOURO UNIVERSITY**

Completion of this document authorizes the disclosure and/or use of health information, about you. Failure to provide *all* information requested may invalidate this Authorization.

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize _____ to release and exchange with and to:

Touro University, 1310 Club Drive, Vallejo, CA 94592
ATTN: Jill Alban, Ed.D.
Phone 707-638-5961 Fax 707-638-5995
Email jill.alban@tu.edu

the following information:

A.
 All health information pertaining to my medical history, mental or physical condition and treatment received [check additional boxes in Section B, as appropriate]

OR

Only the following records or types of health information (including any dates):

B.
I specifically authorize release of the following information (check as appropriate):

Mental health treatment information and notes¹ _____ /Provider Signature

Under the Lanterman-Petris-Short Act your mental health provider (physician, licensed psychologist, social worker or marriage and family therapist) who is in charge of your mental health treatment must approve the release. If the release is not so approved, the reasons therefore should be documented. In the event that the provider fails to sign the release the student must legally obtain a copy of the record himself or herself and then provide the records to Touro University.

- I specifically authorize the release of HIV/AIDS test results. (Health and Safety Code § 12-980 (g))
- I authorize the release of information about drug and/or alcohol abuse, diagnosis or treatment (42 C.F.R. §§ 2.34 & 2.35)

PURPOSE OF DISCLOSURE

The purpose of requested use or disclosure is due to the request of the individual patient (i.e. student) and so that documentation can be provided and the patient’s request for reasonable accommodation considered and discussed with this necessary documentation

EXPIRATION

This Authorization expires [insert date]: _____. If no date is listed than the authorization expires in one year from the date indicated below.

STUDENT’S RIGHTS

You may refuse to sign this Authorization. However, your refusal may have an impact on Touro University’s ability to consider your reasonable accommodation request. You may inspect or obtain a copy of the health information that you are being asked to allow the use or disclosure of.

You may revoke this authorization at any time, but you must do so in writing to the address noted above. Your revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this Authorization. You have a right to receive a copy of this authorization. Information disclosed pursuant to this authorization may be re-disclosed by the Touro University in furtherance of its review of your reasonable accommodation request and, as such it may no longer be protected by California law and federal confidentiality law (HIPAA).

SIGNATURE

Date: _____ Time: _____ am/pm

Signature: _____
(patient/representative/spouse/financially responsible party)

If signed by someone other than the patient, state your legal relationship to the patient:

Witness: _____ Date: _____

This Authorization is presented in 14 point type and otherwise complies with the Patient Access to Health Records Act (PAHRA), Health and Safety Code §§ 123100 – 123149.5, the Confidentiality of Medical Information Act (CMIA), Civil Code § 56 et seq., and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. §164.508, and covers disclosure of medical information by health care providers.



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GENERAL GUIDELINES FOR DISABILITY DOCUMENTATION

Students diagnosed with physical and/or mental impairments qualify as persons with disabilities when their conditions substantially limit them in one or more major life activity. Touro University California provides reasonable accommodations to students with disabilities in consultation from their academic programs. Reasonable accommodations are adjustments to policies, practices, or procedures that facilitate equal access and opportunity for students with disabilities to the University's programs, activities and services. In order to ensure that students' needs are directly linked to these accommodations, Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA) allow higher education institutions to require disability documentation to verify disability status and the need for reasonable accommodations. We have established the following disability documentation guidelines:

Documentation must:

1. Be recent enough in order to assess the current impact on learning or a major life activity. Please see disability-specific guidelines for more information. Please note that students requesting accommodations due to a chronic medical condition must submit documentation dated within 6 months as well as annually updated documentation. In no event will documentation over three years old be considered.
2. Be sufficiently comprehensive to establish clear evidence of a substantial impact on one or more major life activity.
3. Be sufficient to establish a direct link between the underlying impairment and the requested accommodations.
4. Include a description of what mitigating measures the student has used and whether with such use the student may still require accommodation in order to access University programs, activities and services.
5. Be issued by a medical or other qualified, licensed professional, unrelated by birth, marriage or affinity to the student, printed on letterhead, dated, signed, and including the professional's licensing information. No information may be redacted. The University reserves the right to require that a certified copy of the report be transmitted directly from the evaluator to the University.

Documentation also must include:

1. The student's history of receiving reasonable accommodations and academic adjustments, if such history exists.
2. Specific recommendations for accommodations as well as an explanation as to why each is recommended as necessary.

Please also note:

- Referrals for all types of disability evaluations are available from Touro University Student Affairs (SA). The student must bear any cost incurred in obtaining additional information. Please refer to specific documentation guidelines for each type of disability. If the original documentation is incomplete or inadequate to determine the extent of the disability or reasonable accommodation(s), SA has the discretion to require additional documentation.

- Students must complete the application process and submit disability documentation before they may receive accommodations and services. SA reserves the right to deny services or reasonable accommodations while the receipt of appropriate documentation is pending.
- Documentation written in a language other than English must be translated and notarized. All such documentation as well as documentation from outside the United States written in English must follow SA guidelines.