



**Personal Identification and Contact Information:**

Today's Date: \_\_\_\_\_

Term: \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

University ID #: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Drexel Email Address: \_\_\_\_\_

Personal Email Address: \_\_\_\_\_

**Address at which you would like to receive correspondence from The Office of Disability Resources:**

Number and Street: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Country: \_\_\_\_\_

**What is your enrollment status? Select one:**

Prospective Student

Undergraduate Student

Graduate/Professional Student

**What year? Select one:**

Freshman

Junior

Sophomore

Senior

Pre-Junior

Grad/Professional

**Major or Program of Study (i.e. Business, Nursing, Law, etc)?**

Please list here: \_\_\_\_\_

**What is/are the physical location(s) of the academic program or activity for which accommodations are being sought? Select all that apply:**

University City (Main Campus, not including School of Law)

Thomas R. Kline School of Law

Center City Hahnemann Campus

Queen Lane Medical Campus

Burlington County College Campus

Center for Graduate Studies, Sacramento Campus

Online Distance Learner

Other (Please Specify): \_\_\_\_\_

**How would you classify your condition(s) or impairment(s)? Select all that apply:**

Brain Injury

Attention Deficit Hyperactivity Disorder

Autism Spectrum Disorder

Psychiatric Impairment

Chronic Health Conditions

Physical/Mobility Impairment

Hearing Impairment

Visual Impairment

Learning Disability

Other (Please specify): \_\_\_\_\_

**Is this condition temporary or permanent? Select One:**

Temporary

Permanent

**Temporary conditions-expected time for recovery**

Please indicate the expected time required for recovery: \_\_\_\_\_

**What are the limitations associated with the previously listed condition(s)? Select all that apply:**

Seeing

Fatigue

Hearing

Reading

Breathing

Thinking/Concentrating

Eating

Lifting

Sitting

Walking/Climbing Stairs

Sleeping

Fine Motor Control

Functioning of a Major Body Organ or Operation

Standing

Other (Please specify): \_\_\_\_\_

**Is this the first time you are requesting accommodations through Office of Disability Resources? Select one:**

Yes

No

Unsure

### **Accommodations Being Requested**

Please detail any new accommodation requests you may have and/or any new condition you may be presenting at this time. New students – please list the accommodations you are requesting:

**If you have previously received an Accommodation Verification Letter (AVL), are you now requesting the same accommodations for the new term? Select one:**

Yes

No

**Please complete and return this Request for Accommodations Form to**

The Office of Disability Resources:

3201 Arch Street, Suite 210

Philadelphia, PA 19104

Tel: 215.895.1401; Fax: 215.895.1402; [disability@drexel.edu](mailto:disability@drexel.edu)