**The Icahn School of Medicine at Mount Sinai**
**Disability Services**

**Request for Accommodations**

**I. General Information** *(please print)*

**Name** _____ **Male** _____ **Female** _____

**Date of Birth** ___/____/_____ **Student ID #:** _____

**School:** **School of Medicine (SOM)** _____ **Graduate School** _____**/Program**_____

**Permanent Address:** _____

**City** _____ **State** _____ **Zip Code** _____

**Permanent Phone: ( )** _____ **Email Address:** _____

**Local Address: ( ) check here if same as Permanent Address.**

**Local Address:** _____

**Local City** _____ **Local State** _____ **Local Zip Code**_____

**Local Phone: ( )** _____ **Other Email Address:** _____

**II. Nature of Disability/Disabilities, Documentation and Accommodations Requested:**

**What is your disability (diagnosis):** _____
_____

**What documentation are you providing?** _____
_____

**What type of accommodation(s) are you requesting?** _____
_____

**Other pertinent information:** _____
_____
_____
_____
_____

## III. Confidentiality

Information presented in support of the student's request for consideration and accommodation as a person with a disability is considered private and sensitive and will be handled according to the School's FERPA (Family Educational Rights and Privacy Act) policy. The application, supporting documentation, and information from verbal discussions with the student will be kept on file in the Student Disability Services Office. In accordance with FERPA, information from the file will only be shared with other institutional personnel when there is a legitimate educational interest.

**Student Signature:** _____ **Date:** _____

**Please return the completed Request for Accommodations form along with supporting documentation to:**

Christine Low, MSW, LCSW-R
Director, Disability Services
Icahn School of Medicine
1 Gustave L Levy Place, Box 1002
New York, NY 10029-6574
Phone # 212 241-4785
email:christine.low@mssm.edu

## IV. Release of Information (internal source)

In order to arrange for reasonable and appropriate accommodations, it may be necessary for the Mrs. Christine Low, Director, Disability Services for the Icahn School of Medicine at Mount Sinai (which includes the School of Medicine and Graduate School of Biological Sciences) to communicate to the following individuals on your behalf.

I _____ am enrolled as a student in the School of Medicine _____ Graduate School/Program _____/_____ at the Icahn School of Medicine at Mount Sinai. I give permission to **Mrs. Christine Low, Disability Officer for the Icahn School of Medicine at Mount Sinai** to share information with the following individuals on my behalf:

___ Other individuals (counselors, physicians, etc.)

List name and contact information of other individual_____