TURING
SCHOOL OF SOFTWARE & DESIGN

REASONABLE ACCOMMODATION REQUEST

1. To initiate the request process, student should complete Section A. Medical professional should complete Section B. Both should be returned to the Community Engagement Coordinator, Emma Byers, via email emma@turing.edu

Please be aware that your request cannot be considered until Turing has received your completed form and the form from your Healthcare Professional(s) with all of the necessary information. You are urged to submit all of the completed forms and documents as soon as possible so the request can be reviewed prior to the start date of your program.

Please be aware that Turing reserves the right to deny a request if the accommodation sought is not supported by the data in the assessment or documentation.

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SECTION A

STUDENT INFORMATION

Name: _____

Address: _____

Email: _____

Cohort: _____

A2. DURATION

Please indicate the estimated duration for the accommodation(s).

Start Date: _____

Finish Date: _____

A3. HEALTH CARE PROFESSIONALS

The Health Care Professional(s) who will submit information with respect to my condition(s) and accommodation(s) is (are):

Name: _____

Name: _____

Name: _____

Name: _____

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SECTION B

EVALUATION & RECOMMENDATIONS OF HEALTH CARE PROFESSIONAL

Please complete this form and return to Turing School of Software & Design:
CC: Emma Byers, Community Engagement Coordinator
via email at emma@turing.edu

The accommodation request will not be considered until this form is received by the School. You are urged to submit the completed form as soon as possible as the Turing program is very fast paced and students can fall behind quickly.

Please be advised that your assessment must support the request for any accommodation; you must be specific as to why a particular accommodation will compensate for the student's disability. Turing reserves the right to deny a request if the accommodation sought is not supported by the data in the assessment or documentation.

You have the option of submitting a separate letter, but your letter must cover the information requested herein.

Name of Health Care Professional (*print*): _____

Name of Student: _____

Telephone of Health Care Professional: _____

Address of Health Care Professional: _____
(*street, city, state, zip*)
_____

Professional License No. _____

Signature/Date Health Care Professional: _____ Date: _____

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B1. DATE OF FIRST EVALUATION

Please note the first date you evaluated and/or treated this student for the condition(s):

_____

B2. DATE OF MOST RECENT EVALUATION

Please note the most recent date you evaluated this student for the condition for which the accommodation is being required:

_____

B3. DESCRIPTION OF CONDITION(S)

Please describe in detail the student's disability(ies) and the effect the disability has on the student's ability to perform the requirements of the Turing school curriculum. If necessary, attach a separate sheet.

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B4. ESTIMATED DURATION

What is the expected duration of the disability(ies)?

Permanent? Yes_____ No_____

If no, from _____ to _____

Describe your medical recommendations and state:

a) Why and how the proposed accommodation(s) will offset the effect of the disability; and
b) Whether any other accommodations would have a similar effect.
Please be specific with any accommodations (time, duration, etc)

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