

UNIVERSITY OF MIAMI
The Office of Disability Services
ACCOMMODATION REQUEST FORM

Name: _____ C #: _____

Current _____ Address: _____

Telephone: _____ Cell Phone: _____

E-mail Address: _____

Permanent Address: _____

Secondary Contact: _____ Phone: _____

Current Student Incoming Freshman Transfer student Exchange/Study Abroad student

Requesting Services Beginning: Fall Spring Summer

Disability/ Medical Condition: _____

Services Requested: _____

AUTHORIZATION TO RELEASE INFORMATION

I _____ (*please print*) do hereby authorize the University of Miami Office of Disability Services to release and/or discuss information specifically related to my disability; including but not limited to documentation pertaining to my disability, requests or evaluations regarding accommodations, and auxiliary aids and services, with (*check all that apply*):

_____ Members of my family (*specify*): _____

_____ My advisor (*specify*): _____

_____ Medical professional (*specify*): _____

(***Please check***) I do hereby understand that I will receive all official correspondence with the Office of Disability Services via my University of Miami email account or the above email address listed.

Student Signature

Date

Office of Disability Services · University of Miami
University Center, Suite N201
P.O. Box 249003 · Coral Gables, FL 33124
Telephone: 305.284.2374 · Fax 305.284.1999

For Office Use Only

Received: _____

Initialed: _____

For Office Use Only
Received: _____
Initialed: _____