DINING ACCOMMODATION REQUEST FORM

As part of our mission to foster diverse and inclusive learning and living environments, Bates College is committed to supporting students with documented disabilities. As a residential community, Bates prioritizes the residential experience, including dining, as an essential part of our institutional commitment to educating the whole person.

In accordance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act, Bates has established procedures for students with documented disabilities to request reasonable accommodations to help remove a disability access related barrier to their residential experience. The request process requires that students submit this accommodation request form along with any supporting documentation. Please visit the Accessible Education website for guidelines on disability documentation.

Students who encounter a disability related barrier to their dining experience should submit this accommodation request form along with any supporting documentation. Please visit the Accessible Education andStudent Support website for guidelines on disability documentation.

FOR STUDENTS: This form should be completed by your health care professional and returned directly to:

Office of Accessible Education and Student Support
Bates College
48 Campus Ave, Ladd Library G33
Lewiston, ME 04240
Email: accessibility@bates.edu / Fax: 207-786-8290 / Phone: 207-786-6222

TO BE COMPLETED BY THE HEALTH CARE PROFESSIONAL:

This form is to be completed for students requesting a dining accommodation from Bates College based on a documented disability. The Americans with Disabilities Act defines an individual with a disability as “a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such an impairment, or a person who is perceived by others as having such an impairment.” Major life activities include, but are not limited to: caring for oneself, performingmanual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, working, and the operation of major bodily functions.

Student Name:

____

Name of provider: ____

Professional Credentials: ______________________________

Provider Employer: ____

Job Title/Area of Specialty: ______________________________

Based on the above definition, does the individual have a disability? ☐ YES ☐ NO

If yes, please indicate the disability/disabilities: ____

Please provide the code(s) for the disability/disabilities (if applicable): ______________________________

Code source(s): ☐ DSM-V ☐ DSM-IV-TR ☐ ICD-9 ☐ ICD-10

Date of diagnosis:__________Made by you? ☐ YES ☐ NO If not, by whom? __________________________

Number of consultations in past 3 years:________Date of most recent evaluation: ________________________

Length of time under your care: ___________________ Is student currently under your care? ☐ YES ☐ NO

Medical/therapeutic equipment needed:

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Prescribed medications (include dosage):

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Does the student's disability/disabilities substantially limit one or more major life activity? If so, please explain (please use additional space if needed, attachments are welcome):

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Please describe the frequency and severity of the student's symptoms:

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Please discuss the status (static or changing) of the student's condition:

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Please describe any medically necessary modifications you recommend to accommodate the student's disability:

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Please explain how your recommendation(s) would remove any barriers impacting the student's ability to access or participate in the dining experience at Bates (use additional space as needed):

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What are possible alternatives accommodations?

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Accommodations for this disability are recommended:

__ for the next 3-5 months

__ for the next 6-9 months

__ for the next year

__ for the duration of time in college

__ duration unknown

__ other: ______________________________

Additional Comments Pertaining to Request:

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I have attached supporting documentation for this diagnosis ☐ YES ☐ NO

If no, please explain:

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Health Care Professional's Contact Information

Office Address:

Email: ______________________________ Phone: ______________________________

Signature: ______________________________ Date: ______________________________

My signature confirms that I am or have been this student's treating health care professional and that I am not a relative of the student.