Request for Accommodations

Please complete this document if you are requesting accommodations for your educational program at UMA. Please remember that any information you provide is strictly voluntary. This voluntary self-identification allows UMA to begin the evaluation process of your request for accommodations.

Please provide any supporting documentation that will assist in determining appropriate accommodations.

Please fully complete the following:

Student ID# (if known): ________________________ Program of Study: _______________________________

Name: ____ Last four of SS#: ____________________

Email Address: ____

Permanent Address: ____
(Street/City/State/Zip/Country)

Home phone: ____________________ Cell phone: __________________ Work phone: ____________________

The Ultimate Medical Academy campus you are attending (Check one):

☐ Online

3101 W. Dr. Martin Luther King. Blvd.
Tampa, FL 33607
Tel: 888-205-2456
www.ultimatemedical.edu

☐ Clearwater

1255 Cleveland Street
Clearwater, FL 33755
Tel: 727-298-8685
www.ultimatemedical.edu

Describe your disability: ____

____

____

How does this disability affect your learning? ____

____

____

List and explain each of the accommodations you are requesting. Please be as specific as possible:

____

____

____

IMPORTANT: Please read, and if in agreement, sign and date below.

I certify that the information above is accurate.

I understand that some disability-related information may be provided on a need-to-know basis to UMA faculty and staff to help ensure that I receive appropriate accommodations.

This information may be used to evaluate the need for educational services and/or plan an educational program. The use or release of this information is limited to purposes directly connected with my educational program.

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I may revoke this consent at any time except to the extent that action has already been taken. This authority expires with the completion of all transactions related to services provided by Ultimate Medical Academy unless otherwise specified.

Student's Signature: ____Date: ____________________

Please return this **completed sheet** with **supportive documentation** of your disability to Disability Services via email or fax.

Send to: Email: DisabilityServices@UltimateMedical.edu
Fax: 888-333-1454

Ultimate Medical Academy is committed to equality of educational opportunity and does not discriminate against applicants, students or employees based on race, color, gender, national origin, religion, sex or disability.