Policy for Special Needs Reasonable Accommodations

The Site Name AHEC Health Careers Programs (HCP) for high school students strive to increase the number of students entering the health professions in South Carolina. The HCP is designed to develop academically proficient and self-confident future healthcare professionals. Site Name AHEC recognizes that some students may have disabilities or special needs. Site Name AHEC will evaluate each case separately and individually to determine if reasonable accommodations are possible.

An individual with a disability is defined in the Americans with Disabilities Act of 1990 as a person with a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment. It is the responsibility of the student or their parent to proactively self-identify as having a disability and provide adequate documentation from a healthcare provider (the evaluation of the disability is the student's or parent's responsibility) and the student or their parent is responsible for advocacy (e.g., accommodation requests, communicating functional impact of disability, etc).

In order for a reasonable accommodation to be granted, the student, his/her parent, the Health Careers Program Coordinator and the Center Director will develop a written plan which outlines the responsibilities of the student, the AHEC center and the parent(s). The failure of students or parent(s) to meet their responsibilities as defined in the written plan may result in the student being asked to withdraw from the Health Careers Program.

OFFICE OF THE
GENERAL COUNSEL
MUSC/MUHA
* APPROVED AS TO FORM *
By: JCS
Date: 11-11-15

<<AHEC CENTER LOGO>>

Documentation of Diagnosis:

To initiate a request for reasonable and appropriate accommodations, the parent / guardian of the student must provide the AHEC with current documentation of the disability. The Americans with Disabilities Act as Amended defines a disability as a physical or mental impairment that substantially limits one or more major life activities, a record of such an impairment, or being regarded as having such an impairment. The parent / guardian is required to fully complete all sections of this form and submit along with medical documentation of the participant's diagnosed disability.

Program Participant Information

Participant's Name _____

Parent/Guardian _____

Email Address _____@_____.____

Telephone Number (_____)_____-_____

Diagnosis Information *(Please attach test results, e.g. audiology report, PT/OT evaluation, neuropsychological report, etc., and any additional information as necessary.)*

Diagnosing Practitioner's Name _____

Credentials [ ] Physician [ ] Nurse Practitioner [ ] Physician Assistant [ ] Psychologist
[ ] Other _____

Office Telephone Number (_____)_____-_____

Primary Diagnosis _____

Date of Diagnosis _____

Describe the nature and severity of the impairment _____

_____

_____

Is this condition persistent and long-term? [ ] Yes [ ] No

If temporary, what is the expected duration? _____

Medications and/or Corrective Measures *list any prescription medications and/or corrective measures that your child is using to correct or improve the impairment.*

_____

_____

_____

_____

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Substantial Functional Limitations *Definition: Participant is restricted in comparison to the average person in the general population as to the conditions, manner or duration under which activities can be performed.*

How does the impairment, in its corrected or medicated condition, affect the participant in educational activities? Does the condition interfere with the participant's educational activities, and to what extent? List the **substantial functional limitations** (e.g. cannot read regular size print, slow reading speed, slow speech, limited dexterity, or other).

Diagnosis/Condition(s) _____

_____

_____

Educational Activity(ies) Affected _____

_____

_____

Substantial Functional Limitation(s) _____

_____

_____

Requested Accommodation *Please list how the program might accommodate the participant's limitation(s)*

_____

_____

_____

_____

Are there any activities or situations that should be avoided or that would present a significant risk of serious injury for the participant or others? _____

_____

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_____

Parent's Signature _____ Date _____

Participant's Signature _____ Date _____

Thank you for your assistance in providing this information. This completed form and supporting documentation must be submitted to the <<AHEC Center>> by <<DATE>> for consideration of the requested accommodation. The <<AHEC Center>> Health Careers Program coordinator will contact the parent to schedule a date and time to discuss the program's ability or inability to extend accommodation.

-- Official Use Only –
Date Received: _____
Coordinator's Initial: _____