GUIDELINES TO REQUEST TEST ACCOMMODATIONS

Ross University School of Medicine provides reasonable and appropriate accommodations to students with a demonstrated and documented disability. Application for testing accommodations should be made using the Student Request Form found below, and must be accompanied by all necessary documentation; including a written summary of assessment and evaluation results and signed by your healthcare provider along with their recommended accommodations based on your diagnosis.

Please note, however, that RUSM has no control over whether you will obtain similar, if any, accommodations from the United States Medical Licensing Board (USMLE) or from clinical affiliates where you will participate in clinical training during your Clinical Science years. It is your responsibility to seek and obtain accommodations from the USMLE and/or clinical affiliates where you intend to perform clinical rotations as necessary.

Remember to sign and date the application form. Applications should be submitted prior to the beginning of the semester and take approximately 4 weeks to be processed. Incomplete documentation will further delay the administration of your application.

Completed applications should be sent to:

Dr. Ruth Schroeder
Associate Dean for Student Affairs
Ross University School of Medicine
rschroeder@rossmed.edu.dm
STUDENT REQUEST FOR TEST ACCOMMODATIONS

Date of Request:

Name ___________________________       _______________       _______________
Last                                                                First                                                                       M.I.
Date of Birth_______________               Gender:    Male____ Female____
Semester: Winter - Summer – Fall   20___

Permanent Address:
Street____________________________
City_____________________________
State/Province_____________________
Zip/Postal Code_____________________
Country________________________________
Phone:____________________________

Current Address:
Street____________________________
City_____________________________
State/Province_____________________
Zip/Postal Code_____________________
Phone:____________________________

Nature of the Disability:  Check all that apply
Sensory Impairment:  Hearing Disability___    Visual Disability_______
Learning Impairment: Reading Disability______    Writing Disability_______
Mathematics Disability___
Other: ___________    
Language Impairment:  Receptive Language ___    Expressive Language____
Medical Impairments: Mobility/Motor__    Diabetes/Thyroid____
Epilepsy/Neuro__    Other___
Mental Health/Executive: Function Impairments: Anxiety Disorder___    Mood Disorder/Depression__
Attention Deficit___    Other :( Specify)____
Hyperactivity Disorder

**

In order to document your need for accommodation as completely as possible, please attach, in addition to professional documentation, a two-page personal statement (word processed, not hand written) describing your disability and its
impact on your daily life and educational functioning. Do not confine your comments to standardized test performance; rather discuss your overall day-to-day functioning.

How long ago was your disability first professionally diagnosed?
Less than 1 year_____ 1-2 years_____ 2-4 years_____ 5 or more years_______

What accommodation(s) are you requesting? Accommodation(s) must be appropriate to the disability:
Extra time:______________________
Enlarged print:_____________________
Less distracting environment:______________
Use of special equipment:________________
Other (specify):_________________________

Prior classroom or test accommodations that you have received:
Medical College Admission Test (MCAT)
Accommodation Received:_____________________________
(If extra time, note amount given):_____________________
Other Accommodation received:________________________
(If extra time, note amount given):_____________________

My disability has been quantitatively evaluated by:
Physician: _____ Psychiatrist:_______ Psychologist: _______ Optometrist: ________
Audiologist:_________ Physical Therapist: ________ Other: (specify)_________
Provide name and credentials of evaluator:_______________________________

**REMINDER****

*THE APPROPRIATE REPORT IS ATTACHED:

*PERSONAL STATEMENT DESCRIBING MY DISABILITY IS ATTACHED:
I DO HEREBY CERTIFY THAT ALL THE DOCUMENTS AND OTHER INFORMATION SUBMITTED BY ME IS ACCURATE AND FACTUAL TO THE BEST OF MY KNOWLEDGE.

Signature:__________________________________________
Date:______________________________________________

DO NOT SUBMIT

- Original documents; keep the original and submit a copy
- Research articles, resumes, curriculum vitae
- Handwritten letters from physicians or evaluators
- Documentation previously submitted
- Previous correspondence
- Multiple copies of documentation (i.e. faxed and mailed copies of a document)

DO SUBMIT

- Legible copies
- All documents in English. You are responsible for providing certified English translations of foreign language documentation
- Typed or printed letters and reports from evaluators
- Documentation from childhood, if you are requesting accommodations based on a developmental disorder, i.e. LD, ADHD, Dyslexia
- Documentation of functional impairment in activities beyond test-taking
- Documentation of functional impairment beyond self-report