



NOTICE OF APPROVAL OF ACCOMODATION FOR DISABILITY

Name (Last, First): _____

Address: _____

Phone: _____ E-mail: _____

The accommodations listed below that you have been approved to receive are effective on _____ [date]:

1. _____
2. _____
3. _____
4. _____
5. _____

These accommodations are approved for the following period(s):

Fall Quarter 20__ Winter Quarter 20__ Spring Quarter 20__ Summer Quarter 20__

If you need accommodations beyond the period indicated above, please submit updated recommendations from your health provider at least two weeks prior to the quarter in which accommodations are being requested.

Provost

Student Services Department

Date

Date

Be Inspired