



REQUEST FOR ACADEMIC ACCOMMODATIONS

Student Legal Name: _____ Today's Date: _____

Student Preferred Name: _____ Pronouns: _____
(optional) (optional)

Student ID #: _____ Date of Birth: _____

Contact Information:

Street Address: _____

City: _____

State: _____ Zip Code: _____

Cell Phone: _____

Email Address: _____

What semester/year did you begin taking classes at SUNY Schenectady? _____

What is your program/field of study? _____

1. What is/are your diagnosed disability/disabilities? _____

2. How does your disability impact your performance as a student? _____

3. Are you receiving educational support services through ACCES-VR?

☐ Yes ☐ No ☐ In application process

If yes, who is your ACCES-VR counselor and what is their contact information?

4. Are you a veteran? ☐ Yes ☐ No

5. Are you a dependent of a veteran? ☐ Yes ☐ No

6. Would you like assistance from the Disability Resource Office with voter registration? ☐ Yes ☐ No ☐ Already Registered to Vote

7. Please list any accommodations you have received in the past.



RELEASE AUTHORIZATION

I, _____, _____
Print Legal Name SUNY Schenectady ID #

give the Disability Resource Office permission to exchange information about my disability with the following agencies/people, sharing all pertinent information:

_____ All SUNY Schenectady personnel involved with my education and related services/resources

_____ ACCES-VR

_____ Commission for the Blind and Visually Handicapped

_____ Other Agency: _____

_____ Emergency Contact: _____

Student Signature

Date