REQUEST FOR ACCOMMODATIONS UNDER SECTION 504 of the REHABILITATION ACT of 1973
2010-2011 SCHOOL YEAR

Student's Name: Last: _____ First: _____ Middle: _____

Male: _____ Female: _____ D.O.B: _____ I.D. #: _____

Borough: _____ District: _____ School: _____ Grade: _____ Class: _____

School Address: _____ Zip Code: _____

Physician's Statement for Requested 504 Accommodations (if applicable):

1. Describe the nature of the concern: _____

2. Medical Diagnosis/Disability: _____

3. Describe how the disability affects the student's educational performance: _____

4. List/describe the educational service(s) that are being requested: _____

_____ _____
Physician's Name (Print) Physician's Signature

_____ _____
Physician/Clinic's Address NYS Registration No. Date Signed

_____ _____
Zip Code Physician/Clinic's Telephone No. Physician/Clinic's Fax No.

Parent's Statement for Requested 504 Accommodations:

1. Describe the nature of the concern: _____

2. Describe how the disability affects the student's educational performance: _____

3. List/describe the 504 accommodations that are being requested: _____

To determine whether 504 accommodations are necessary, a 504 team will convene to review your request. If a 504 Accommodation Plan is necessary it will be completed by the school with your input. This plan must be reviewed annually.

By submitting this Request for 504 Accommodations, I am requesting that my child be provided with specific educational accommodation(s)) by the New York City Department of Education (the "Department"). I have provided the full and complete information regarding this request for educational accommodation(s) in this form. I understand that the Department, its agents, and its employees involved in the provision of the above-requested accommodation(s) are relying on the accuracy of the information that I have provided in this form to determine whether and to what extent my child will be provided with accommodations under Section 504.

Please Print Parent/Guardian's Name & Address Below:

_____ _____
Parent/Guardian's Signature

_____ _____
Date Signed

_____ _____
Daytime Telephone No.

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2010- 2011

DO NOT WRITE BELOW
(FOR NYC DEPARTMENT OF EDUCATION USE ONLY)

Student's Name: _____ **OSIS No:**_____

Reviewed by: _____ _____
Name (Please Print) **Title** **Date**

Request for Educational Service(s)

Approved _____ **Denied** _____ **Referred for Further Review** _____

Reason Request Approved or Denied:

Referred to CSE _____ **Sent to School 504 Coordinator** _____

Date of Referral _____ **Date of 504 Team Mtg.** _____

_____ _____
Signature **Date**

10-11