Associated Barber College of San Diego

1333 5th Ave San Diego, Ca 92101

Reasonable Accommodations Request Form

1. To initiate the request process, please complete both sides of Section A and return the form to the admissions office, Associated Barber College of San Diego, 1315 5th Avenue, San Diego, CA 92101.

2. Have your health care professional complete Section B and return it to the admissions office. If there is more than one Health Care Professional responding on your behalf, each must complete a separate form.

3. Please be aware that your request cannot be considered until Associated Barber College of San Diego has received your completed form and the form from your Health Care Professional(s) with all of the necessary information. You are urged to submit all of the completed forms and documents as soon as possible, as the review process can extend over a minimum of thirty days.

4. Please be aware that Associated Barber College of San Diego reserves the right to request independent evaluations before granting or extending a request for a reasonable accommodation. In addition, Associated Barber College of San Diego reserves the right to deny a request if the accommodation sought is not supported by the data in the assessment or documentation.

Section A. Student Information

_____

Last Name First Name M.I

_____

Address City State Zip Code

(_____)_____

Telephone

A1. Please describe specifically the reasonable accommodation(s) you are requesting and your reasons for the request. Also, describe any alternative suitable accommodations. Attach additional sheets, if necessary.

_____

_____

_____

Continued on Other Side

Section A. Student Information (continued)

A1. Reasonable accommodation(s) (continued)

_____

_____

_____

_____

_____

_____

A2. State the estimated duration for the accommodation(s).

Theory Classroom

Tuesday _____(am/pm) to _____ (am/pm)

Wednesday _____(am/pm) to _____ (am/pm)

Thursday _____(am/pm) to _____ (am/pm)

Friday _____(am/pm) to _____ (am/pm)

Saturday _____(am/pm) to _____ (am/pm)

Practical Floor

Tuesday _____(am/pm) to _____ (am/pm)

Wednesday _____(am/pm) to _____ (am/pm)

Thursday _____(am/pm) to _____ (am/pm)

Friday _____(am/pm) to _____ (am/pm)

Saturday _____(am/pm) to _____ (am/pm)

A3. The Health Care Professional(s) who will be submitting information with respect to my condition(s) and accommodation(s) is (are):

_____

_____

_____

_____

_____ _____

Signature **Date**

Associated Barber College of San Diego

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Section B. Evaluation and Recommendations of Health Care Professional

1. Please complete both sides of this form and return it to the Admissions Office at Associated Barber College of San Diego, 1315 5th Avenue San Diego, Ca 92101. The accommodation request will not be considered until this form is received by Associated Barber College of San Diego. You are urged to submit the completed form as soon as possible as the review process can extend over a minimum or thirty days.
2. Please be advised that your assessment MUST support the request for any accommodations; you must be specific as to why a particular accommodation will compensate for the student's disability. Associated Barber College of San Diego reserves the right to deny a request if the accommodation sought is not supported by the data in the assessment or documentation.
3. You have the option of submitting a separate letter, but your letter must cover the following points:

_____

Please print – Name of Health Care Professional

_____

Street Address City State Zip Code

(_____)_____

Telephone No.

_____

Name of Student

B1. Please note the first date you evaluated and/or treated this student for the condition(s):

_____

B2. Please note the most recent date you evaluated this student for the condition for which the accommodation is being required:

_____

Continued on Other Side

Section B (continued)

B3. Has the Health Care Professional reviewed our barber programs curriculum and the catalog?

https://sandiegobarbercollege.com/enrollment/educational-programs/

https://sandiegobarbercollege.com/wp-content/uploads/2016/10/Student-Catalog-2016-816.pdf

Yes_____ No_____

B4. After reviewing the barber program curriculum and catalog please describe in detail the student's disability/ disabilities and the effect the disability has on the student's ability to perform the requirements of the law school curriculum. If necessary, attach a separate sheet.

_____

_____

_____

_____

_____

_____

_____

B5. What is the expected duration of the disability/ disabilities?

Permanent? Yes_____ No_____

If no, from _____ To_____

B6. Describe your medical recommendations and state:

a) Why and how the proposed accommodation(s) will offset the effect of the disability; and,

b) Whether any other accommodations would have a similar effect.

_____

_____

_____

_____

_____ _____

Signature of Health Care Professional Date Professional License No.