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, 1333 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.  

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**Section A. Student Information**  

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>M.I</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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<tbody>
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(______)___________________  

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).

<table>
<thead>
<tr>
<th>Theory Classroom</th>
<th>Practical Floor</th>
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<tbody>
<tr>
<td><strong>Monday</strong></td>
<td><strong>Monday</strong></td>
</tr>
<tr>
<td>____ (am/pm) to ____</td>
<td>____ (am/pm) to ____</td>
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<tr>
<td><strong>Tuesday</strong></td>
<td><strong>Tuesday</strong></td>
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<tr>
<td>____ (am/pm) to ____</td>
<td>____ (am/pm) to ____</td>
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<td><strong>Wednesday</strong></td>
<td><strong>Wednesday</strong></td>
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<tr>
<td>____ (am/pm) to ____</td>
<td>____ (am/pm) to ____</td>
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<td><strong>Thursday</strong></td>
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<td>____ (am/pm) to ____</td>
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<td><strong>Friday</strong></td>
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<td>____ (am/pm) to ____</td>
<td>____ (am/pm) to ____</td>
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<td><strong>Saturday</strong></td>
<td><strong>Saturday</strong></td>
</tr>
<tr>
<td>____ (am/pm) to ____</td>
<td>____ (am/pm) to ____</td>
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</tbody>
</table>

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signature                       Date
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, 1333 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://associatedbarbercollege.edu/office/student-catalog.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.

______________________________________________________________________________
______________________________________________________________________________
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______________________________________________________________________________

Signature of Health Care Professional                        Date                        Professional License No.