

REQUEST FOR ACCOMMODATIONS UNDER SECTION 504 of the REHABILITATION ACT of 1973
2013-2014 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/ICD-9 code: _____

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	Date Signed
Physician/Clinic's Address	NYS Registration No.	
Zip Code	NPI No.	Medicaid No.
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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2013-2014

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/IEP Team _____		Sent to School 504 Coordinator _____	
Date of Referral _____		Date of 504 Team Mtg. _____	
_____ Signature		_____ Date	