UNIVERSITY of MARY

STUDENT ACCESSIBILITY SERVICES
Application for Dining Accommodations

Student Please Complete

The University of Mary contracts with University of Mary Dining Services to provide on-campus dining services for students. The Allergies Avast station within the University Dining Center offers special dietary options available to all students. This station features items made without the top eight allergens (peanuts, tree nuts, eggs, fish, shellfish, milk, wheat, and soy) as well as gluten.

Students who follow a special diet are invited to discuss their needs with our Resident Dietitian at (701) 355-3787. The Resident Dietitian and student will meet to develop a plan for the student's dining needs.

Requests for dining accommodations are granted when the student has submitted sufficient documentation demonstrating the student has a disability and the requested accommodation is medically necessary based on the current functional limitations of the disability. Exceptions to the requirement to purchase a meal plan on the basis of a disability are granted only if the student's needs cannot be accommodated in the University of Mary dining facilities. If the student's needs cannot be met, the student must register with Student Accessibility Services. To register with Student Accessibility Services, proof of medical necessity is required.

Applications for dining accommodations should be made as soon as the student has decided to attend University of Mary; a 30 day notice is preferred. All requests are reviewed on a case by case basis.

Student Name _____ **ID#** _____ **Date** _____

Class ❑ Freshman ❑ Sophomore ❑ Junior ❑ Senior ❑ Grad ❑ Transfer ❑ Non-degree seeking

Cell Phone _____ **U-Mary Email** _____

Major(s) _____ **Advisor(s)** _____

Residence Hall _____ **Room Number** _____ ❑ Not yet assigned

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Disabilities and Accommodations

Please list any food allergies that have an impact on your ability to utilize campus dining. It is necessary to supply supporting documentation for each area of disability for which you will require accommodations.

_____

_____

_____

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_____

_____

7500 University Drive Bismarck, ND 58504 office (701) 355 8264 fax (701) 255 7687

Please describe how you are affected functionally by the food allergies noted above.

_____

_____

_____

_____

_____

_____

Based on your documented food allergies and functional limitations, please describe the accommodation(s) you are requesting to receive. Accommodations may not be applied retroactively.

_____

_____

_____

_____

_____

_____

When are you seeking accommodations to be implemented? ☐ Fall ☐ Spring ☐ Summer Year _____

☐ **I am not seeking accommodations at this time.**

I certify to the best of my knowledge that the information on this form is true and complete without evasion or misrepresentation. I understand that if found to be otherwise, it is sufficient cause for rejections or dismissal. I understand that I will need to provide supporting disability documentation to support the need for my requested accommodations. I understand that reasonable accommodations are determined after a thorough review of the provided information and an individualized, interactive intake meeting between the Coordinator of Student Accessibility Services and me.

Student Signature _____ **Date** _____

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Medical Provider Please Complete

To qualify for disability accommodations at the University of Mary, a student must have a documented disability which substantially limits one or more major life activities as outlined in Section 504 of the Rehabilitation Act and the Americans with Disabilities Act as amended. This form must be completed by the diagnosing professional, who should not be a relative of the student.

Student Accessibility Services will use your information to determine this student's eligibility for reasonable dining accommodations at the University of Mary.

Student's Name: **Date of Birth**:

Name and Credentials of Evaluator:

Date of Most Recent Evaluation:

Diagnosis (DSM or Medical):

Diagnostic methodology used and specific results:

Describe how this disability might limit the student functionally in relation to dietary needs, in terms of how significantly the activity is affected by the disability, the frequency with which the activity is affected, and how pervasive the disability is in the performance of the activity.

(Continued to next page)

Describe current treatments or medications and their effectiveness in relation to dietary needs. Information about any significant side effects from the current treatment or medication and its effect on physical, perceptual, behavioral, and cognitive performance is helpful.

Describe expected progression or stability of the disability including expected changes over time, information on the cyclical or episodic nature of the disability and any known suspected environmental triggers.

List recommendations for dietary accommodations and explain how each minimizes or compensates for the functional limitations of this student's disability.

The requested accommodation(s) is/are _____ Medically Necessary _____ Medically Beneficial *(Please check one)*

Attach any additional information that verifies the functional limitations of the disability.

I certify that the information submitted represents this student's **present level of functioning**.

_____ _____

Signature and Credentials ***Print Name*** ***Date***

_____

Organization (or attach business card)

_____

Organization Address

_____

Organization Phone