



## **POLICY REGARDING ACCOMMODATIONS FOR DISABLED STUDENTS**

### **INTRODUCTION**

New England College of Business is an institution with a diverse population of students. We pride ourselves on our compliance with applicable standards for meeting the needs of students with disabilities. Pursuant to the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act (Section 504), the College provides equal opportunity for qualified persons with disabilities. As appropriate, the College will make reasonable accommodations to offer persons with disabilities the opportunity to participate fully in its programs, activities and services.

### **WHAT IS A “REASONABLE ACCOMMODATION?”**

A reasonable accommodation is an adjustment that allows a student with a disability to participate fully in the College educational experience.

### **PROCEDURES FOR REQUESTING ACCOMMODATIONS**

Accommodations must be formally requested by the student in writing. ***All requests should be made to the NECB Provost.***

Students are encouraged to provide the College with prompt notice of their needs to allow time for an interactive process to take place between the student and College.

To enable The College to timely provide an auxiliary aid or service, The College requests that this application be completed and returned four (4) weeks before the first day of classes, or otherwise as soon as practicable. Please note that auxiliary aids or services will not be provided until a completed application is received by the Provost.

To request an accommodation, a student must complete and submit the attached Accommodation Request Form, along with supporting documentation from his or her licensed health care professional. That documentation should be current (no more than three years old) and must include:

1. A diagnosis of the disability and any accompanying testing results;
2. A detailed description of the specific impairment, limitations, functional need, and the medical justification for such need;
3. A recommendation for the type and duration of the accommodation(s) needed; and
4. The professional credentials (specialty; licensure, etc.), contact information, and signature of the health care provider.

**APPLICATION FOR AUXILIARY AID**

Dear Prospective Student:

It is important that you complete and return this application and supporting documentation well in advance of your enrollment if you are not yet a student. To enable The College to timely provide an auxiliary aid or service, The College requests that this application be completed and returned four (4) weeks before the first day of classes, or otherwise as soon as practicable. If you are a current student, you should complete the application and submit documentation as soon as you are aware of a disability-related need for auxiliary aid or service. Please note that auxiliary aids or services will not be provided until a completed application is received by the Provost.

**I. BACKGROUND INFORMATION**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent Address \_\_\_\_\_

City, State Zip \_\_\_\_\_

Permanent Phone (\_\_\_\_) \_\_\_\_\_ E-mail address \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_

Cellular Phone (\_\_\_\_) \_\_\_\_\_ Country of Citizenship \_\_\_\_\_

**II. ACADEMIC HISTORY**

<u>Secondary Colleges Attended</u>	<u>Dates of Attendance</u>		<u>Disability Related Accommodation/Services Used*</u>
	<u>From</u>	<u>To</u>	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

\* If an Individualized Education Program (IEP) was developed, please provide a copy of the IEP.

<u>Colleges/Universities Attended</u>	<u>Dates of Attendance</u>		<u>Disability Related Accommodation/Services Used</u>
	<u>From</u>	<u>To</u>	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**III. GENERAL NATURE OF DISABILITY/DISABILITIES**

Describe below the nature of your disability and list the specific auxiliary aids or services requested. Please attach a current medical certification stating the nature of your disability and supporting your need for the auxiliary aids or services requested. To be considered current, the certification must have been completed by a health care professional within three (3) years from the date submitted.

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**IV. FINANCIAL SPONSORSHIP**

You are encouraged, but not required, to register with a state vocational rehabilitation agency or similar agency.

Will your attendance at this institution be funded in part or in whole by a vocational rehabilitation program?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify your vocational rehabilitation counselor:

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Are you receiving financial sponsorship from a source other than a vocational rehabilitation program?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please identify the source of the financial sponsorship:

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Date)

Please return to:

Provost  
New England College of Business  
10 High Street  
Suite 204  
Boston, MA 02110  
617-951-2350