Aspen University
4615 E. Elwood Street, Suite 100
Phoenix, AZ 85040

(Effective Date: 11/1/2023)

Request for Pregnancy/Postpartum Accommodations

Student Information:

Student Name: Learner ID Number:

Phone Number: Email:

Program/Specialization:

Type of Request

- ☐ Pregnancy
- ☐ Childbirth
- ☐ Postpartum
- ☐ Other, please specify:

Please indicate the activities below that you believe are impacted by your condition:

- ☐ Eating
- ☐ Standing
- ☐ Sitting
- ☐ Walking
- ☐ Other, please specify:

Describe in as much detail as possible how the condition impacts your ability to perform the requirements of your course:

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Please indicate the specific accommodations you are requesting for your courses:

By submitting this form, you are agreeing to allow the Accessibility Office to communicate with faculty, staff, administrators, and clinical education staff to facilitate implementation of any approved accommodation in your classes and program of study. You also understand that the implementation of some accommodations, may require some level of disclosure to the appropriate faculty and staff. The Accessibility Services Office seeks to minimize disclosure whenever possible.

Student Signature:

Date:

NOTE: Please return completed forms to accessibility@aspen.edu

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Medical Provider Verification of Pregnancy or Postpartum Needs

Medical Provider: This student is requesting accommodations from the Accessibility Office based on pregnancy or postpartum needs. The University, for the purposes of establishing reasonable accommodations, requires current information about the nature of the student's condition. The information submitted will be reviewed on a case-by-case basis, specifically looking at the impact of the condition on this individual and within the specific context of the requested accommodations.

Student Name: Date of Birth:

Provider Name: Phone Number:

License or Certification: Provider Email Address:

Provider Mailing Address:

Provider Credentials/Area of Specialty:

Is the above-named student **currently** under your care?

☐ Yes ☐ No

What is the date of your last clinical contact with the student?

What condition(s) are you currently treating the individual for?

Please indicate the extent to which the condition currently impacts this individual and how it could impact their academic experience. Please include the duration of impact, severity of the condition, and any additional information you deem appropriate for us to consider.

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What accommodations do you recommend for this student during their pregnancy or postpartum?

Please provide any additional information you believe is pertinent to our consideration of the student's accommodation request.

Provider Signature:

Date:

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