UNIVERSITY OF KANSAS MEDICAL CENTER
EQUAL OPPORTUNITY OFFICE
STUDENT/RESIDENT INFORMATION (ADA) FORM

Name: _____ Date: _____

Current Address: _____

Permanent Address: _____

E-Mail Address: _____ Day Phone: _____

Pager Number: _____ Evening Phone: _____

Student/Resident Information

Resident Year _____ Program _____

Medical Student ☐ Yr1 ☐ Yr2 ☐ Yr3 ☐ Yr4 ☐ M.D./Ph.D

Nursing Student ☐ Jr. ☐ Sr. ☐ BSN ☐ M.S. ☐ Ph.D.

Allied Health ☐ Jr. ☐ Sr. ☐ Graduate Program _____

Graduate Student ☐ Master's ☐ Ph.D. Program _____

Expected Date of Graduation_____

Medical Information

Medical/psychiatric condition(s): _____

_____

_____

Impact of Condition(s) on School Performance, Attendance and/or Conduct: _____

_____

_____

I understand information provided to the KUMC EOO will generally remain strictly confidential. However, the EOO may disclose limited information on a need-to-know basis to support the accommodation process.

_____ _____

Signature Date

Referred by: ☐ Self ☐ Friend ☐ Dean ☐ Faculty ☐ Other

Revised: 04/08/2004