



Department of Speech and Hearing Science
Speech-Language-Hearing Clinic
141 Pressey Hall
1070 Carmack Road
Columbus, OH 43210-1002

614-292-6251 Phone
614-292-5723 Fax

sphs.osu.edu/clinic

Accommodation Request

Date: _____

Name: _____

Clinical Advisor: Amy Sonntag

I have obtained documentation from the Office of Disability Services for a recognized need for accommodations. A copy of the ODS letter is attached.

I am requesting the following accommodations to facilitate my success in the OSU SHS clinical program, please be specific (paperwork, daily schedule, etc):

____ The above request has been approved by the OSU SHS clinical personnel

____ I understand that these requested accommodations are to be discussed with each preceptor at the beginning of each rotation/semester. The accommodations must be approved by the preceptors to determine appropriateness to that site and to the profession.

Graduate Clinician Signature: _____

____ I approve of the above accommodations (adjustments may be added by the preceptor and initialed).

Preceptor Name: _____ Signature: _____