Request for Meal Plan Exemption

Student Name: _____ Student ID: _____

Phone number: _____

Student email: _____

Academic Classification: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐

Graduate ☐ Other: _____

Campus housing: ☐ Yes ☐ No

Purpose

The Center for Accessibility is committed to providing equal access to university programs and services, including campus dining, for students with documented disabilities or qualifying medical conditions.

Students requesting meal plan exemption should complete this form and have the Healthcare Provider Verification section completed by an appropriately licensed healthcare provider.

The Center for Accessibility will review each request individually and, when appropriate, work collaboratively with the student based on the student's documented disability-related needs.

Submission of this form does not guarantee approval.

Request Information

Meal plan exemptions are considered on an individual basis for students with documented disabilities or medical conditions that substantially limit their ability to participate safely in the University's required meal plan. Students are encouraged to contact the Center for Accessibility before submitting this request to discuss available accommodations.

I have discussed my needs with the Center for Accessibility: ☐ Yes ☐ No

I authorize my Healthcare Provider to release information related to disability or medical condition, if necessary, to the appropriate Faulkner University personnel for the purpose of evaluating my request for meal plan accommodation. I understand that this information will be used only for determining appropriate accommodation and will remain in accordance with applicable privacy laws and university policy.

☐ Yes ☐ No

Student signature: _____ Date: _____

To be completed by physician

Diagnosis: _____ Date of onset: _____

Please describe how the student's disability or medical condition affects their ability to safely utilize the University dining plan.

_____

_____

Please explain why the student is unable to meet their dietary needs through the University's dining program, including available food choices and reasonable dining accommodations.

_____

_____

_____

Please describe the medically necessary diet and dietary restrictions. (If available, please attach supporting documentation.) _____ _____

_____

Duration of Need

The requested accommodation is expected to be:

☐ Temporary

Expected end date: _____

☐ Ongoing/Permanent

Healthcare Provider Information:

Provider Name: _____

Title/Credentials: _____

Practice or Clinic: _____

Address: _____

Phone number: _____ Fax number: _____

I certify that the information provided above is accurate and based on my professional evaluation of this patient.

Physician's signature: _____ Date: _____

Faulkner University
Attn: Director of Center for Accessibility
5345 Atlanta Hwy
Montgomery, AL 36109

Please return to: