

Authorization to Provide Clinical Preceptors Accommodations Notification



**Marshall B.
KETCHUM UNIVERSITY**
University Student Affairs

Student Name: _____ Student ID: _____

Program: _____ Class Year: _____

Email: _____ Cell Phone: _____

Pursuant to your request for an accommodation, this is to advise you that Student Disability Services (SDS) may provide information about your accommodation request and disability-related needs to your assigned **Clinical Preceptors**.

FERPA ACKNOWLEDGEMENT

SDS adheres to the confidentiality standards set by the Federal Family Educational Rights and Privacy Act (FERPA), which, provides exceptions for the releases described above. Under this federal law, in some circumstances, prior written consent by the student may be required before SDS may release disability documentation and/or records. This document will serve as written authorization for SDS to share information as needed in order to implement your accommodation request.

Your signature below indicates that you have read this information, that you understand the role of the above parties in implementing accommodation(s) based on your documented needs, and that you are hereby authorizing SDS to share your accommodations-related information with the above indicated persons, and as needed, for the purpose of addressing your accommodation needs.

EFFECTIVE DATE

You understand that this authorization will be valid from the date you sign this form and seek the assistance of SDS, until you graduate from the Marshall B. Ketchum University, unless you revoke this authorization in writing at any time before the information is released.

Should you have questions about FERPA or this document, please email studentaffairs@ketchum.edu.

STUDENT SIGNATURE

DATE



**DISABILITY
SERVICES**