

Section 504 Accommodation Plan

Student's Name: _____ Technology Center: _____

Beginning Date: _____ Ending Date: _____

DETERMINATION OF ELIGIBILITY FOR 504 SERVICES

Describe the student's physical or mental impairment: _____

Does the physical or mental impairment substantially limit one or more major life activity? Yes ____ No ____

This student does _____ or does not _____ qualify for Section 504 of the Rehabilitation Act of 1973.

AREA OF NEED	ACCOMMODATIONS	RESULTS/STATUS REVIEW

Location of services if other than the regular classroom setting and reason(s) necessary: _____

Comments: _____

Participants Signature	Position/Title	Date

I have been informed and received notice of this plan and have received Section 504 information and procedural safeguards.

Student

Date