



SPECIAL NEEDS SERVICES REQUEST FORM for COMMENCEMENT
Wednesday, May 21, 2008

DUE DATE: APRIL 30, 2008

Name of Student:

_____ (Last)

_____ (First)

UMDNJ School:
(check one)

- School of Nursing NJ Medical School School of Health Related Professions
- School of Osteopathic Medicine School of Public Health RWJ Medical School
- NJ Dental School Graduate School of Biomedical Sciences

Name of Special Needs Guest:

_____ (Last)

_____ (First)

Name of Contact Person:
(if other than student name above)

_____ (Last)

_____ (First)

Contact Address:

Contact Phone Number:

Contact Person E-mail:

Specific Needs (Please check corresponding lines):

Sign Language Interpreting: _____

Audio Booster: _____

Other Needs (Please explain):

Name of person accompanying special needs guest:

Please return this form to:

Office of Workplace Diversity
Attn: Ms. Laxmi Vazirani

University of Medicine and Dentistry of New Jersey
Stanley S. Bergen Building
65 Bergen Street

Newark, New Jersey 07107

Telephone Number for Questions: 973-972-4855

This information is confidential and will only be shared with persons involved with providing accommodations.