



AIM
Access in Medicine



DRP
ACADEMY

The Disability Resource Professional's Guide to Clinical Accommodations in Undergraduate Medical Education

October 2025

DOCS
WITH DISABILITIES
— INITIATIVE —

Acknowledgements

The Docs with Disabilities Initiative (DWDI) extends gratitude to the following individuals who shared their expertise in the creation of the content of this publication:

**Matthew A. Sullivan,
PhD**

**Grace C. Clifford,
MAEd**

**Lisa M. Meeks,
PhD, MA**

DWDI would also like to acknowledge the following individuals for their assistance in the review and editing of this publication's content:

Jaime Axelrod, MS

**Rosezetta Henderson,
MS**

**Christine Low,
MSW, LCSW-R**

Rylee Betchkal, MS

Ifeoma Ikedionwu, MD

Aggie McGrane, MS

Jennifer Biggers, MEd

**Kara James,
MS, CRC, PVE**

Nora Newcomb, MD

Jessica Campanile, MD

**Peppar E. P. Cyr,
MD, PhD, MPhil**

Ellen Kaplan, MEd

Suchita Rastogi, PhD

Jan Serrantino, EdD

**Zainub Dhanani,
MD, MS**

**Zakariya Khaleel,
MD, MS**

**Sarah Triano,
MS, NCC, LPC**

Emily Langham, MS

Suggested Citation (AMA): Sullivan, M, Clifford, GC, Meeks, LM, et al. The DRP Guide to Clinical Accommodations in Undergraduate Medical Education. (October 20, 2025) Docs with Disabilities Initiative Website.

<https://www.docswithdisabilities.org/>



**Alliance
Disability
Inclusion
Equity**



Table of Contents

Acknowledgements.....	1
Table of Contents.....	2
Introduction.....	4
Intended Audience and Use of Guide.....	4
How This Guide Was Developed.....	4
Disclaimers.....	4
To Disability Resource Professionals (DRPs):.....	4
To Students:.....	5
To Educators/Administrators:.....	5
Foundational Concepts of Clinical Accommodations.....	6
What Are Clinical Accommodations?.....	6
The Critical Role of a Specialized Disability Resource Professional (DRP).....	7
Understanding the Legal Framework for Clinical Accommodations.....	7
Balancing Access and Upholding Standards.....	8
Evaluating the Need for Clinical Accommodations.....	8
Evaluating the Need for Clinical Accommodations.....	8
Maintaining Professionalism.....	10
Putting It Into Practice: An Example.....	10
Building Collaborative Protocols for Determining Clinical Accommodations.....	11
Accommodation Determination.....	13
Determining Disability.....	14
The Student Interview.....	14
Establishing Access Barriers and Determining Accommodations.....	16
Denying Accommodations.....	16
Documenting Decision Making.....	17
Accommodation Letters.....	18
Creating a Collaborative Notification Process.....	18
Timely and Transparent Communicating Accommodation Letters.....	18
Tailoring Letters to Context.....	19
Constructing the Clinical Accommodation Letter.....	19
Conclusion.....	21

Note on Resources.....	22
Recommended Reading:.....	22
Clinical Accommodations:	
Categories and Considerations.....	23
Use of Language for Accommodation Letters.....	24
Individualized Adjustments/Needs.....	25
Adaptive Equipment.....	27
Assistive Technology.....	28
Location-Based Accommodations: Purpose and Communication.....	30
Common Misconceptions and Clarifications.....	30
Scheduling.....	32
Leave Time for Disability-Related Appointments.....	33
Rotation Schedule Continuity: Ensuring Consistent Access.....	33
Accessible Approaches to Overnight Call Requirements.....	34
Decompressed Clerkship Blocking.....	34
Communication Access.....	35
Communication Tip Sheets/Memos.....	36
Conclusion.....	38
Appendix A. Individualized Adjustment/Need.....	39
Appendix B. Adaptive Equipment.....	43
Appendix C. Assistive Technology.....	46
Appendix D. Location.....	49
Appendix E. Scheduling.....	50
Appendix F. Communication Access.....	52
Appendix G. Clinical Experiences.....	55
Appendix H. Example Clinical Accommodations Letter.....	57

Introduction

Intended Audience and Use of Guide

This guide provides an overview of determining and implementing reasonable accommodations in undergraduate medical education (UME). Built on a foundation of 75 vetted accommodations currently in use at U.S. medical schools, it offers consensus-based language for communicating about accommodations. Additionally, the guide clarifies the process for determining clinical accommodation and supports a deeper understanding of clinical accommodations currently in use.

How This Guide Was Developed

The accommodations presented in this guide originated from a modified [Delphi study](#) that compiled clinical accommodations currently in use at nine U.S. medical schools. The language was refined through multiple rounds of expert review to ensure clarity, accuracy, and consistency. This study marked the first published report on specific clinical accommodations language in U.S. medical education. As always, medical schools will need to be responsive to future advancements in technology and changes in medical education curriculum and delivery that may impact the reasonable nature of accommodations. This guide is co-developed and sponsored by Medical Students with Disability and Chronic Illness (MSDCI), the Disability in Medicine Mutual Mentorship Program (DM3P), the Stanford Medicine Alliance for Disability Inclusion and Equity (SMADIE) and the Docs With Disabilities Initiative (DWDI).

Disclaimers

Determining reasonable accommodations must always be an individualized, interactive, and legally grounded process, evaluated within the context of each specific medical school program. While many examples may be relevant to other health science programs, this guide is designed exclusively for medical education. Users are encouraged to review the guide in full before consulting the clinical accommodation examples. This document is intended as an educational resource—not a directive.

To Disability Resource Professionals (DRPs):

This guide is intended to *inform* and *support* the legally grounded, individualized, and interactive process required to determine reasonable clinical accommodations. It does **not**

replace or substitute for that process. Every accommodation decision must be made on a case-by-case basis, within the specific program context, and only after appropriate documentation review and engagement with the learner and relevant faculty.

Clinical accommodations should never be treated as a checklist, menu, or automatic process based on disability category (e.g., “if this, then that”). The process begins by establishing whether a disability exists, identifying functional limitations, and assessing barriers within the educational or clinical environment. Accommodations—including those referenced in this guide—should only be considered after this interactive and iterative dialogue.

This guide highlights a range of *formally approved* accommodations (i.e., those determined after documentation review and an interactive process). It is not an exhaustive catalog of all possible accommodations. While students may use self-mitigating strategies and certain teaching practices, program structures, or faculty flexibility may naturally reduce barriers, this guide addresses *formal accommodations only*.

To Students:

The accommodations described here are examples, not a complete list of all possible options. Every accommodation decision is made individually, taking into account your specific program, curriculum, and environment. An accommodation approved in another setting—including those outlined in this guide—may not automatically apply to your program, nor does its inclusion suggest it is appropriate or available for all students.

To Educators/Administrators:

The absence of a specific accommodation in this guide does not imply that it is unreasonable. This guide reflects accommodations reported by a limited number of schools in one study. Other literature—including case studies and book chapters—demonstrates the breadth and depth of potential clinical accommodations.

Foundational Concepts of Clinical Accommodations

What Are Clinical Accommodations?

Clinical accommodations are modifications, adjustments, or the use of assistive technology and auxiliary aids in clinical learning environments, including clerkship rotations. Their purpose is to remove disability-related barriers to learning for medical students with disabilities while upholding program requirements, professionalism standards, and patient safety, thereby ensuring equitable participation.

At their core, clinical adjustments fall under the broader concept of a *reasonable accommodation*—a legally defined change or modification that provides equal access without imposing an undue burden on the institution or fundamentally altering the essential requirements of a program (Americans with Disabilities Act of 1990; Section 504 of the Rehabilitation Act of 1973). Reasonable accommodations can take many forms, including adjusted call schedules or the use of accessible medical equipment. Importantly, accommodations are never about lowering academic or professional standards. Rather, they ensure that students can demonstrate their knowledge and skills under equitable conditions, consistent with the program’s essential requirements and patient safety obligations.

While classroom-based accommodations are widely recognized and routinely implemented, clinical accommodations have only recently begun to receive meaningful attention. Emerging research documents the significant barriers students encounter in clinical education and the downstream consequences of inadequate access—including compromised well-being, lower board performance, and delayed graduation. These findings underscore the urgent need to embed accessibility into all aspects of medical education, with particular attention to the clinical training environment.

Because the demands of each clerkship are dynamic and specialty-specific, expertise in both disability services and medical education is essential to ensure that accommodation decisions are rigorous, precise, and do not result in a fundamental alteration of the program. Disability Resource Professionals (DRPs) must therefore be well-versed in the principles of clinical accommodations and the unique structures of their institution’s curricula. Whereas most classroom-based accommodations are relatively straightforward, clinical accommodations are inherently more nuanced. In this setting, a legally grounded, collaborative, and precise

interactive process is critical to fostering inclusion while maintaining the integrity of medical education.

The Critical Role of a Specialized Disability Resource Professional (DRP)

A specialized Disability Resource Professional (DRP) with expertise in medical education is essential. Research demonstrates wide variation in the training and experience of DRPs in medical schools, and this variability directly affects students' access, academic performance, and ability to secure critical downstream supports such as board examination accommodations. A knowledgeable DRP can mean the difference between a student thriving or encountering unnecessary barriers.

Faculty members bring indispensable expertise in their disciplines and clinical teaching, but are not expected to be authorities on disability law or accommodation practices. Without a specialized DRP who understands both medical education and the legal framework, institutions risk making decisions that are inconsistent, inequitable, or legally vulnerable.

By embedding specialized DRPs throughout the accommodation process, programs create a stronger and more precise foundation for access. This ensures that determinations of what is reasonable versus unreasonable are informed by clinical and educational realities, while firmly grounded in the legal and ethical standards that govern medical training.

Understanding the Legal Framework for Clinical Accommodations

Clinical education is not an “optional” component of medical training but a core curriculum requirement. Accordingly, the legal protections that apply in the classroom extend fully into hospitals, clinics, and all other educational environments. Two federal laws form the backbone of these protections: the Americans with Disabilities Act, as amended (ADA-AA), and Section 504 of the Rehabilitation Act of 1973. Together, these statutes prohibit discrimination against qualified students with disabilities and require medical schools to provide reasonable accommodations that ensure equal access to the curriculum.

The ADA-AA applies to public (Title II) and private (Title III) medical schools, while Section 504 covers all institutions receiving federal funding—nearly every medical school in the United States. These obligations do not end at the classroom door. Because clerkships, rotations, and

placements are integral to becoming a physician, schools must also guarantee access in the clinical environment, including at affiliated hospitals or external training sites.

Balancing Access and Upholding Standards

The law balances the obligation to provide accommodations with important limits. Institutions are not required to:

- Fundamentally alter the essential nature of a program;
- Implement accommodations that would impose an undue burden;
- Lower academic, clinical, or technical standards; or
- Excuse unprofessional behavior.

These boundaries ensure that accommodations promote equity and access without compromising the integrity of medical education or the safety of patient care.

Evaluating the Need for Clinical Accommodations

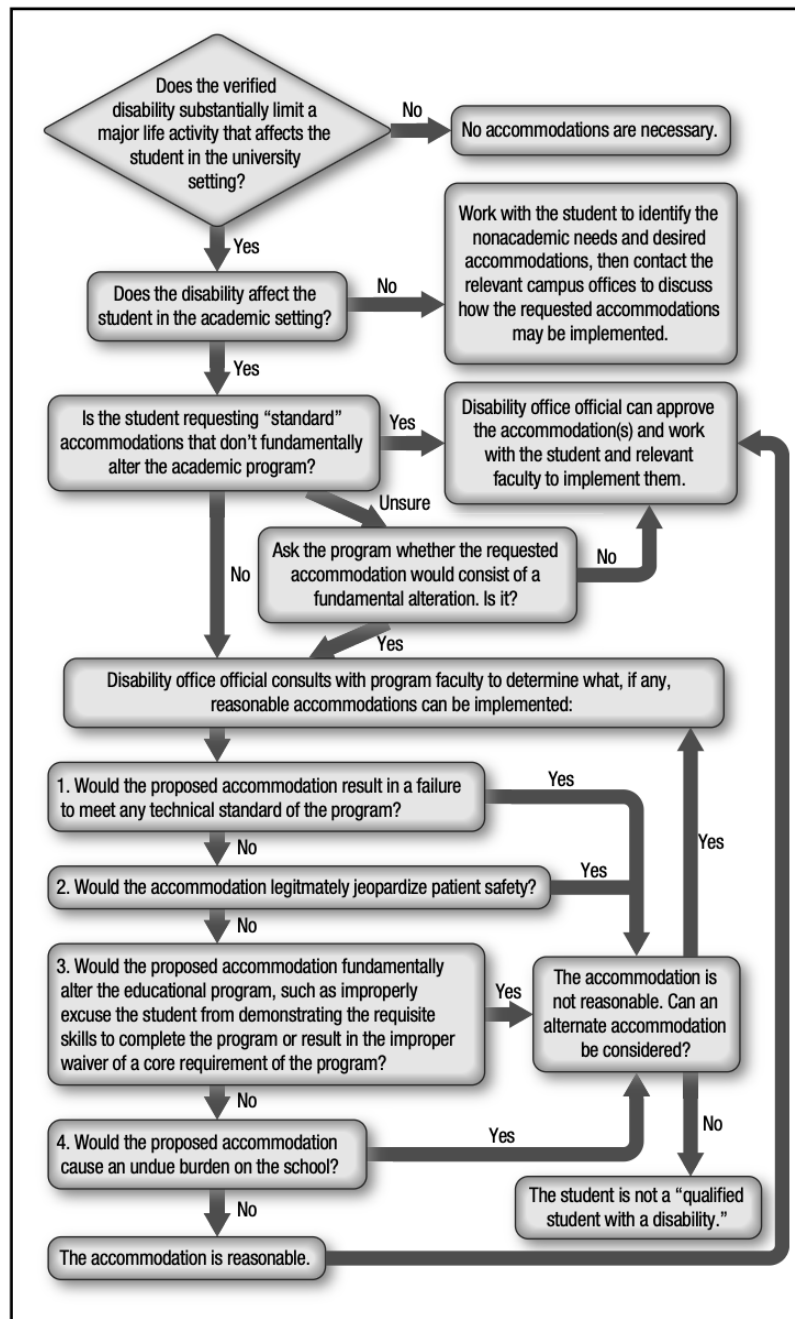
Evaluating the Need for Clinical Accommodations

A case-by-case evaluation— the *interactive process*—is central to the legal framework for disability inclusion. This process requires schools to engage directly with the student, along with institutional representatives such as Disability Resource Professionals (DRPs) and faculty, to identify how disability-related barriers can be removed without compromising essential program outcomes.

Rather than relying on blanket rules or one-size-fits-all responses, the interactive process emphasizes deliberation, collaboration, and precision. Each decision must balance the unique functional limitations of the learner, the demands of the clinical environment, and the integrity of medical education. A diagram of this process (see Figure 1), adapted from *Equal Access: Universal Design of Instruction in Postsecondary Education*, illustrates the decision-making pathway for determining reasonable accommodations.

Figure 1. Practice Recommendation Determining Appropriate Accommodations

(Adapted with permission from Meeks, Jain, Laird, *The Guide to Equal Access for Students with Disabilities in Health Science and Professional Education*, 2020).



Maintaining Professionalism

Professionalism is often discussed in the context of disability inclusion, and schools may question whether behaviors or symptoms related to a disability that are deemed unprofessional in the medical school context need to be accommodated. In both regulatory terms and case law, professionalism remains non-negotiable.

For example, the Liaison Committee on Medical Education (LCME) and federal case law recognize professionalism as an essential requirement, on par with patient safety and ethical practice. While schools must provide accommodations that support access, they are not required to lower professionalism standards. For instance, in *Halpern v. Wake Forest University Health Sciences* (2012), the court upheld a school's decision to dismiss a student who repeatedly violated professionalism expectations, despite his ADHD and anxiety diagnoses. Similarly, in *Saxena v. University of Massachusetts Medical School* (2022), the court concluded that while the student had received accommodations, ongoing failures to meet academic and professional standards justified dismissal.

Putting It Into Practice: An Example

A third-year medical student disclosed to the Disability Resource Professional (DRP) that a chronic health condition significantly impaired their ability to function the day following an overnight call, leading to repeated tardiness in clinic. After reviewing the student's documentation—which remains confidential within the DRP's office—the DRP engaged in the interactive process with the student and clerkship leadership to evaluate possible accommodations.

Through this process, the team determined that a portion of the eight required overnight shifts could be substituted with evening or early-morning shifts. This adjustment mitigated the disability-related barrier while preserving the essential requirement of exposure to clinical care. The student was advised to re-engage with the disability office should further barriers arise.

Despite this accommodation, the student continued to arrive late. In such circumstances, persistent tardiness is appropriately addressed as a professionalism concern. Students with disabilities remain accountable to the behavioral expectations of the clinical environment; accommodations ensure equitable access to learning but do not exempt learners from meeting the professional standards integral to medical training.

Building Collaborative Protocols for Determining Clinical Accommodations

A DRPI—whether embedded within the medical school or shared from the undergraduate campus—typically leads the interactive process. On some campuses, responsibility may instead involve human resources or other administrators. To outline best practices, this guide assumes the process is grounded in the leadership of a medical school specialized DRP.

To ensure an effective and legally sound accommodations process, DRPs must cultivate strong, collaborative relationships with program leadership, including those responsible for curriculum, assessment, student support, and clinical education (see Table 1. *Key Attributes to Building Collaborative Relationships*). Before engaging individual clinical directors or instructors, DRPs should meet with program leadership to establish a shared framework for communication and decision-making. This framework should clarify who will participate in discussions, how information will be conveyed, and the steps for evaluating and implementing accommodations in clinical settings.

Once this structure is in place, DRPs can engage the relevant clinical leaders responsible for direct instruction, supervision, and assessment. Ideally, these procedures should be established before student-specific requests to ensure the process is coordinated, efficient, and transparent. Proactive planning facilitates timely accommodation determinations, strengthens trust, reinforces program requirements, and ensures accommodations align with educational standards and clinical realities.

Table 1. Key Attributes to Building Collaborative Relationships

Goal	Action
<i>Establish Leadership Alignment</i>	Identify program leaders, clarify shared goals, define communication protocols, and confirm essential elements associated with curricular design, assessment mechanisms, overall programmatic standards, and the delivery of student support.
<i>Define Roles and Responsibilities</i>	Identify who must be included in accommodation discussions and determine each party's role in the evaluation and decision-making process. Programmatic partners could include, but are not limited to, the following: course directors/faculty, clerkship directors, simulation center, student affairs, and hospital personnel (as needed).
<i>Create Communication Pathways</i>	Establish clear methods for sharing accommodation-related information, define who qualifies as a "need-to-know" party, and implement confidentiality safeguards to ensure only essential personnel are involved.
<i>Develop a Standardized Evaluation Process</i>	Outline how clinical accommodation requests will be reviewed, including the determination of disability status, analysis of accommodation-related needs pertaining to specific clinical environments, and necessary accommodations to remove disability-related access barriers. Create a process for how decisions about potential fundamental alteration will be deliberated and documented.
<i>Plan for Implementation</i>	Establish clear decision timelines, define communication channels for approved accommodations, and train faculty and partners on protocols. A troubleshooting system and a public-facing outline must be in place for emergent issues to promote transparency and learner trust. This process should be formally documented to ensure consistency of practice in the event of organizational restructuring or staff transition.
<i>Engage in Continuous Review</i>	Create an ongoing feedback mechanism with program leadership and clinical faculty/staff, regularly revisiting and refining protocols to enhance transparency, timeliness, and equity.

Accommodation Determination

As with accommodations in the didactic phase of medical education, determining accommodations for the clinical setting involves several critical steps: establishing the presence of a disability, understanding the student's disability-related experiences and functional limitations, and identifying potential access barriers within clinical environments (*see Box 1. The Accommodation Determination Process*). Once accommodations are determined, programs must also engage in ongoing monitoring to ensure their effectiveness and adjust as needed.

The following section expands on each of these components and underscores their importance in developing support plans that are effective, context-specific, and legally sound.

Box 1. The Accommodation Determination Process

The process of determining accommodations in medical education typically involves four key components:

1. Formal Request for Accommodations

Students generally initiate the process by submitting a formal request, often facilitated through a written request form or an online portal routed directly to the Disability Resource Professional (DRP).

2. Submission of Disability-Related Documentation

Documentation from a qualified provider is generally required to establish disability status. This information assists in identifying areas of functional limitation, their severity, and the potential impact on academic and clinical performance.

3. Collaborative Discussion Between DRP and Student

Dialogue between the DRP and the student is essential to understand the student's disability-related experiences, clarify functional limitations, and explore explicitly stated requests for accommodation. This discussion ensures that the student's lived experience remains central to the process.

4. Assessment of Potential Barriers in the Clinical Environment

Beyond the student's stated needs, the DRP—in collaboration with program leadership—should anticipate barriers likely to arise in the clinical setting (e.g., shift scheduling, use of medical equipment, communication in fast-paced team environments). This forward-looking step helps ensure accommodations are responsive to the unique demands of clinical education while maintaining essential program outcomes.

These components are not strictly sequential and may occur in varying order. However, engaging in all four is generally necessary before an official accommodation determination can be made.

Determining Disability

The ADA-AA defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Applying this definition in medical education requires nuance. All students, regardless of disability status, face steep learning curves as they acquire new physical, cognitive, and interpersonal skills. These challenges are a natural part of professional training and should not automatically be interpreted as disability-related barriers.

The Disability Resource Professional (DRP) plays a critical role in distinguishing between ordinary learning-curve challenges and genuine accessibility barriers. Making this distinction with accuracy and empathy strengthens trust with students, builds credibility with faculty, and ensures that accommodations remain effective, reasonable, and aligned with legal requirements and educational goals. This process begins with a robust and thoughtful student interview.

The Student Interview

The intake interview is a cornerstone of the accommodations process. While documentation may establish eligibility, the interview uncovers how a student's disability intersects with the unique demands of medical training. It serves as a practical tool for identifying barriers and accommodations and as a relationship-building moment that fosters trust, respect, and partnership. By engaging with the student's lived experiences, anticipated stressors, and prior strategies, the DRP can anticipate barriers and recommend accommodations that promote access while minimizing the risk of symptom exacerbation. Helpful conversation starters are outlined in *Figure 2. Ten initial questions for guiding the student intake* and in *The DRP Guide to First-Time Student Interviews*.

Figure 2. Ten initial questions for guiding the student intake
(Adapted with permission from Meeks, Jain, and Laird, Equal Access, 2020).

1. How does your disability impact you in daily life (e.g., socially, academically, with work, and with self-care)?
2. How do you mitigate the impact independently, and how have you mitigated this impact in an educational setting?
3. What, if anything, exacerbates or worsens your disability?
4. Do you have a history of needing to receive treatment, or do you anticipate needing to receive treatment such that you may need to 'step out' of the curriculum at some point to attend to disability-related needs?
5. Have you ever worked in a clinical setting, or do you anticipate additional barriers during the clinical portion of your education? (may need to prompt with example competencies)
6. Have you reviewed the technical standards of the program and the competencies for each rotation? If not, we can do this together to identify any potential barriers.
7. Have you ever used assistive technology to mitigate the impact of your disability on a task (e.g., writing, reading)?
8. Have you ever used adaptive equipment? If the student has never been in a clinical setting, it may be helpful to ask how they interact with everyday items (depending on the disability), like listening to music, using the phone, or cooking. This can prompt a discussion about how one might navigate the clinic, for example, a deaf or hard-of-hearing student using a pager system or a student with mobility disabilities navigating clinical spaces with multiple medical tools or devices.
9. Do you take any medication that impacts (positively or negatively) your ability to function (e.g., medication that causes drowsiness or allows a student to focus for a sustained amount of time)?
10. What are your biggest concerns about entering this program?

Establishing Access Barriers and Determining Accommodations

Once disability status has been identified, the DRP's next step is to examine program requirements in light of the disability's functional impact to determine accommodations that are reasonable, appropriate, and necessary. A clear understanding of the following terms provides the foundation for this process:

- **Disability:** A condition that substantially impacts one or more major life activities.
- **Functional Impact:** The practical ways a disability influences a student's ability to complete tasks or participate fully in training.
- **Access Barrier:** A program structure or element that creates unequal participation for students with disabilities.
- **Accommodation:** A modification or adjustment that reduces or removes barriers, promoting full access and engagement.

Grounded in these concepts, DRPs should continually ask: *What is necessary to ensure access and inclusion in this setting?*

Denying Accommodations

Accommodations may be denied when the requested support is determined to be unreasonable or inappropriate based on available evidence. These decisions are never made in isolation but through collaboration between the DRP, relevant program officials, and institutional leadership.

A request is considered **unreasonable** when it meets one or more of the following criteria:

- It would fundamentally alter essential curricular or programmatic elements.
- It would substantially change the manner in which a program or service is delivered.
- It would create a legitimate health or safety risk to others.
- It would impose an undue financial or administrative burden (though this argument has rarely been sustained in practice).

A request may be considered **inappropriate** when it does not rise to the level of “unreasonable” but still lacks sufficient justification. Common examples include:

- No identifiable barrier exists to substantiate the need.
- A disability cannot be established through documentation or a credible self-report.

Regardless of whether a request is deemed unreasonable or inappropriate, the decision-making process must be carefully documented. The student should receive:

- A clear explanation of the rationale for the decision.
- Recommendations for alternative supports or accommodations that may be available.
- Information about the institution’s process for reconsideration, appeal, or grievance.

Documenting Decision Making

Once accommodations have been reviewed with relevant clinical faculty, the DRP should document the decision-making process in their notes (see: *AHEAD White Paper: Documenting Disability Professional and Student Interactions: Reasons and Recommendations for Notes*). Documentation should clearly capture:

- Who was involved in the review.
- Any alternative accommodations considered or offered.
- Whether external consultation (e.g., other DRPs, deans, peer schools, or content experts) informed the decision.

Denials should be addressed promptly, ideally within two weeks. When a request is denied, the rationale must be documented with particular care. Notes should include:

- A detailed account of how the decision was reached.
- A description of any alternative accommodations proposed.

Thorough documentation ensures transparency, promotes consistency across cases, and reinforces accountability in the decision-making process.

Accommodation Letters

Creating a Collaborative Notification Process

Accommodation letters are the primary mechanism for communicating approved clinical accommodations to those responsible for teaching, supervision, and assessment. These letters serve two purposes: (1) to ensure that accommodations are communicated and implemented consistently and effectively, and (2) to protect student privacy by sharing only the information necessary for access.

Within this framework, students should be considered partners in the notification process and empowered to discuss their accommodation-related needs with clerkship leadership and clinical site educators. However, assigning sole responsibility for this task to the student is strongly discouraged. Clinical accommodation notification requires an in-depth understanding of administrative logistics associated with each clerkship rotation—such as placement options, scheduling, and identifying the correct leadership contacts. Without this knowledge, students are at a significant disadvantage.

As partners in the process, DRPs should discuss the student's comfort level, clarify expectations for communication about accommodations, and, when appropriate, offer opportunities to role-play disclosure conversations. These practices improve communication skills, reduce anxiety, and reinforce that the student is supported (see: *Appendix 8.1 Communication Guide for Student and Appendix 8.2 Communication Guide for Faculty in The Guide to Equal Access for Students with Disabilities in Health Science and Professional Education*).

For these reasons, we recommend that the DRP assume responsibility for distributing accommodation notifications. By coordinating with the curricular affairs team and clinical leadership, the DRP ensures that appropriate faculty and staff are informed in a consistent, timely, and professional manner. This approach reduces bias, safeguards student privacy, and strengthens accountability in implementing accommodations.

Timely and Transparent Communicating Accommodation Letters

For accommodations to be effective, letters must be distributed promptly and accurately. Institutions should establish clear protocols defining when notification occurs, who is responsible for delivery, how receipt is confirmed, and how information is shared across the

clinical rotation. Transparency throughout this process is critical: students and faculty should know what to expect, when, and from whom.

At the same time, privacy must be preserved. Information should be shared only with those with a legitimate “need to know”—the educators and supervisors responsible for facilitating and implementing accommodations in the clinical setting. This balance ensures both effective communication and respect for student confidentiality.

Tailoring Letters to Context

Accommodations may vary across rotations, and letters should be tailored accordingly. For example, a student with rheumatoid arthritis who requires a disposable vaginal speculum in OB/Gyn clerkships would not need this accommodation in a Psychiatry clerkship. Similarly, some accommodations are administrative rather than clinical—such as schedule or placement adjustments—and should be shared only with the registrar or clerkship director, not with clinical educators. Aligning letters with specific needs in each setting ensures relevance, precision, and protection of student privacy.

Constructing the Clinical Accommodation Letter

Clinical accommodation letters must be rotation-specific and should not include accommodations relevant only to classroom, testing, or laboratory contexts. Overly broad or comprehensive letters risk introducing unnecessary information, potentially compromising clarity and student privacy. Focused communication ensures that clinical educators receive only the information required to facilitate equitable participation.

The literature and best practice guidelines suggest that clinical accommodation letters include the following elements:

- **Overview of Disability Resources** – situating the letter within the institutional framework that coordinates and supports accommodations.
- **Purpose of Accommodations in the Clinical Setting** – articulating accommodations as mechanisms that promote equity in access rather than preferential treatment.
- **Rights and Responsibilities** – providing a succinct description of reciprocal expectations for students and educators.
- **Approved Accommodations** – delineating accommodations specific to the clinical context, written in precise and actionable language.

- **Contact Information** – identifying the DRP as the point of contact for clarification or follow-up.

Balancing clarity with brevity is critical. Letters that achieve this balance communicate both the legal and ethical responsibilities of clinical educators and the centrality of accommodations in supporting the success of MSWD. For a sample clinical accommodations letter, please refer to Appendix H.

Conclusion

Creating equitable and accessible learning environments in medical education requires sustained collaboration, flexibility, and commitment from DRPs, faculty, administrators, clinical site partners, and students. This guide is offered as a foundational resource, providing examples of reasonable clinical accommodations that have been successfully implemented in undergraduate medical education across the country.

The accommodations described here are not exhaustive or prescriptive. Rather, they are intended to inform institutional practice and inspire innovation as programs engage in the interactive process. Each decision should be made on a case-by-case basis, with careful attention to the student's individual needs and the essential clinical training requirements. Balancing flexibility with consistency fosters inclusive learning environments while preserving academic integrity and ensuring patient safety.

Ultimately, the success of clinical accommodations depends not only on sound policies but also on proactive communication, intentional planning, and continuous education. When leadership, faculty, DRPs, and clinical partners remain engaged and committed to accessibility, MSWDs are able to fully participate in clinical education. In doing so, the medical education community strengthens its commitment to equity and cultivates a physician workforce enriched by the diverse talents, experiences, and perspectives of all learners.

Note on Resources

While this guide offers focused direction, additional resources are available for those seeking a deeper exploration of this topic. Several comprehensive books provide greater detail and practical strategies. Portions of this guide have been adopted, with permission, from *Advancing Disability Inclusion in Medical Education: Case Studies and Practical Insights*, a forthcoming book by Dr. Lisa Meeks, scheduled for publication in 2026.

Recommended Reading:

Meeks LM, Neal-Boylan L, eds. *Disability as Diversity: A Guidebook for Inclusion in Medicine, Nursing and the Health Professions*. Cham, Switzerland: Springer Nature Switzerland AG; 2020. <https://link.springer.com/book/10.1007/978-3-030-46187-4>

Meeks LM, Jain N, Laid-Metke E, eds. *Equal Access for Students with Disabilities: The Guide for Health Science and Professional Education*. 2nd ed. New York, NY: Springer Publishing; 2020. Available for free download: <https://www.docswithdisabilities.org/equal-access-guide>.

Meeks LM, Neal-Boylan L, eds. *Disability as Diversity: A Case Studies Companion Guide*. Cham, Switzerland: Springer Nature Switzerland AG; 2021. <https://link.springer.com/book/10.1007/978-3-030-55886-4>

Clifford, GC*, Sullivan, M*, Triano, S, Magee, E, Gossett, J, Beetchkal, R, Serrantino, J, Axelrod, J, Meeks, LM. Medical school terminology guide for disability resource professionals. Access in Medicine. Program of the Docs With Disabilities Initiative. (n.d.) <http://www.docswithdisabilities.org/>

Meeks, LM*, Jain, NR*, Triano, S, Guler, R, Nahm, S, Serrantino, J, Kaplan, E, Clifford, G, O'Connor, C. The Guide to requesting accommodations on the USMLE Step examinations. Meeks, LM, Jain, NR (editors). The Docs with Disabilities Initiative. Access in Medicine Program. September 2023. <https://www.docswithdisabilities.org/usmle-accommodations-guide>

Clinical Accommodations: Categories and Considerations

The categories of clinical accommodations presented in this guide are the result of a Delphi review process conducted with DRPs from nine U.S. medical schools, disability experts, and clinical phase medical students. These professionals, with extensive experience supporting students within health sciences and medical education, and lived experience as people with disabilities, contributed their expertise to refine and standardize the language and practices for clinical accommodations. The accommodations outlined here reflect real-world practices that have been successfully implemented across a variety of institutions.

The following section organizes clinical accommodations into six distinct categories:

1. *Individualized Adjustments/Needs,*
2. *Adaptive Equipment,*
3. *Assistive Technology,*
4. *Scheduling,*
5. *Location, and;*
6. *Communication Access.*

Some categories, such as *Scheduling* and *Location*, are relatively straightforward, while others, such as *Individualized Adjustments*, require more detailed explanation to ensure they address the specific needs of the MSWD while aligning with clinical requirements. Each category is accompanied by examples and considerations to ensure the accommodations are effective and appropriate in the clinical setting.

These accommodations are designed to provide practical, applicable solutions that support students' access while maintaining program integrity.

This guide offers examples of reasonable accommodations but is not intended to cover every possibility. Each student's needs must be considered individually, through an interactive and legally grounded process. The guide is meant to serve as a supportive resource for DRPs and faculty as they identify and implement accommodations, while recognizing that the individualized process remains essential to ensuring equity and access.

Use of Language for Accommodation Letters

Constructing clinical accommodation language is an intentional process that requires both attention to detail and consistency in word choice. In this section, accommodation descriptions typically use the phrasing “*student will utilize*” or “*student requires*.”

“Student will utilize”: Refers to items or equipment a student already possesses and brings into the clinical environment (e.g., a personal portable stool or handheld magnifier).

“Student requires”: Refers to equipment, supports, or resources that are necessary but outside of the student’s direct control, and therefore must be provided or made available by the institution.

Using these phrases consistently helps ensure clarity, transparency, and shared understanding across faculty, DRPs, and clinical partners. Intentional word choice and writing style are key attributes that promote consistency and equity when crafting clinical accommodations (see example Table 2. *Examples of the difference between student will utilize/student requires*).

Table 2. Examples of the difference between “Student will Utilize/Student Requires”

Accommodation Statement	Accommodation Description
<i>Use of Finger Splints</i>	Student will utilize finger splints during patient evaluations and procedures. [DRP/University should discuss and implement alternative accommodations for procedures that, due to the sensitive nature of the exam, may require alternative devices/approaches.]
<i>Use of Grip Enhancements for Medical Tools</i>	Student will utilize gripping materials, such as foam tubing on handheld instruments (e.g., scalpels, reflex hammers, tuning forks), to enhance handle size and increase the friction of surface area. [DRP/University should determine appropriate grip enhancements with the assistance of the clinical site/rotation director and determine whether the institution, student, or site will purchase/provide.]

<i>Use of Texturized Surgical Gloves</i>	Student requires texturized surgical gloves for all clinical learning opportunities involving the use of surgical gloves. [DRP/University should determine the type of texturized surgical glove (e.g., Microflex gloves, Dynarex Sterile Latex Surgical Gloves, Ansell Gammex Non-Latex PI Ortho).]
---	--

Aligned with the commitment to intentionality and clarity, accommodation descriptions in this guide include bracketed detail indicating where the DRP or university must specify the required accessible attributes. For example, if a student requires *“use of texturized surgical gloves,”* the accommodation letter should clarify the exact type of glove needed (e.g., *“Student requires Microflex texturized surgical gloves for all clinical learning opportunities...”*). Providing this level of specificity ensures that clinical educators clearly understand student needs and are well-prepared to create an accessible learning environment.

Individualized Adjustments/Needs

While all accommodations address disability-related impacts and barriers specific to an individual, individualized adjustments or needs refer to student-specific support that involves modifying standard practices. In contrast to adaptive equipment or assistive technologies, which focus on integrating specific devices or software, individualized adjustments highlight areas that require advanced preparation, timely notification, or increased awareness. “Advanced Notice of Assigned Patients” entails the need for additional notice for effective preparation as outlined below:

Example Accommodation-Advanced Notice of Assigned Patients/Records

The student requires the ability to arrive early for the shift to review patient/chart information. When students are not permitted/able to arrive prior to clinic opening, alternative options should be implemented (e.g., allowing the student to remain after their completed shift to review patient assignments/information for the next day, remote access to patient assignments, etc.). [DRP/University should include scheduling/access specifics.]

When implementing this accommodation, the DRP should work with the clerkship placement coordinator to ensure that the student receives updated information about clinical sites as early as possible. This may involve prioritizing sites where advance notice is more feasible (e.g.,

outpatient clinics, surgical centers) and, when necessary, excluding sites where timely updates cannot be provided. For specialties that inherently allow limited notice (e.g., emergency medicine), the DRP should establish a plan with site leadership to share information as quickly and consistently as possible. Another example of an individualized adjustment is the need for additional time to complete charting (see below).

Example Accommodation-Additional Time to Complete Patient Notes

Student requires additional time outside of clinical hours to complete patient notes.

[DRP/University should specify how extended access will be provided (e.g., access to the clinical site before or after assigned hours, access to patient records via a secure VPN on an approved personal device, etc.).]

Before implementing time-based accommodations, the DRP should review the productivity expectations of the clinical setting and determine how additional time for charting can be achieved. In many settings, students may arrive early or stay late to complete notes. In clinics with limited operating hours, the accommodation may be better supported through secure remote access, such as the ability to VPN into the system or submit notes through an alternative secure platform. This approach has become increasingly common and feasible across institutions.

The final example, *Assistance with Manual/Physical Tasks and Maneuvers*, promotes awareness of need and stipulates specific parameters associated with physical ability (see below).

Example Accommodation-Assistance with Manual/Physical Tasks and Maneuvers

Student requires assistance performing clinical tasks involving the act of lifting, pulling, pushing, and/or carrying items over ["X amount of weight"]. [DRP/University will clarify specific physical restrictions with the student and discuss implementation within the clinical site.]

When constructing this type of accommodation, programs should be as specific as possible in identifying any adaptive equipment or assistive technologies the student will need. For example, if physical assistance is required due to limited hand function, the accommodation letter might also include access to speech-to-text dictation software.

As the examples above illustrate, many accommodations naturally align with or reinforce one another. While not a strict rule, requests in this category are often accompanied by other formal supports, resulting in multiple accommodations being approved for the student. DRPs should be

trained to clearly outline the purpose of each accommodation so that faculty and staff understand how they function together, reducing the likelihood of concerns that a student is being “overly accommodated.”

Adaptive Equipment

In general, adaptive equipment is closely linked to individualized adjustments or needs; the key distinction lies in the specification of particular equipment. Some items may be small and unobtrusive (e.g., noise-reducing earplugs), while others are larger and more visible (e.g., adaptive furniture or workstations). For many accommodations in this category, advance notice of the accommodation is just as important as the accommodation itself (see example below).

Example Accommodation-Noise-Reducing Ear Plugs when Charting

Student may utilize a noise-reduction device (in-or over-ear) to minimize environmental distractions while reviewing/documenting patient interactions. [DRP/University should include device specifics.]

The use of noise-reducing earplugs is generally not a concern; however, formal notification is still required. Additionally, discussions should take place to ensure appropriate use so that noise reduction does not interfere with the learner’s ability to respond to patient-related needs.

Other adaptive equipment, such as the use of a stool within the clinic setting, may involve two approaches. First, notification that the university/program must provide a portable stool for the student to use during rounds and other activities that involve standing for extended periods. In these situations, it is important to specify that the accommodation reduces a barrier, but that the student is still engaging in discussions and patient care. Clear communication about the accommodation and use will prevent preceptor inquiries and clear up misunderstandings related to professionalism.

Example Accommodation-Use of Portable Stool

Student will carry and utilize personal portable [indicate type of stool] stool during rounds and clinical duties. [DRP/University will need to indicate whether this is a seated stool or a step stool. They will also need to indicate what environments the stool cannot be utilized in (e.g., OR, secure units, etc.) and what alternatives should be provided within these settings.]

Second, the accommodation should stipulate the need for a stool within environments where the personal stool may not be permitted:

Example Accommodation-Access to Stool/Chair in Sterile Environments

Student requires the ability to periodically sit or stand within sterile environments and requires access to a stool/chair while maintaining the sterile field. [DRP/University should discuss protocol with the student for obtaining a stool/chair within sterile environments.]

DRPs should be deliberate in their word choices and consistently review accommodation language to ensure clarity. Seeking feedback from clinical educators can also be valuable, helping confirm that the language is clear, appropriate, and easy to implement in practice.

Assistive Technology

Accommodations in this category are all associated with programs/software that are commonly associated with the use of a computer or other handheld devices. Two of the most common forms of assistive technology are the use of text-to-speech and speech-to-text programs (see examples below).

Example Accommodation-Use of Text-to-Speech:

Student will utilize text-to-speech software to access electronic text. [DRP/University should identify and implement text-to-speech software compatible with the clinic site's secure systems.]

Example Accommodation-Speech-to-Text Dictation Software for Charting/Notating Purposes:

Student will utilize dictation software for notes/charting purposes and must have access to charting stations equipped with dictation software. [DRP/University should identify/implement compatible dictation software.]

Text-to-speech and speech-to-text tools can be implemented in multiple ways, each with distinct strengths and limitations. For example, dictation and other assistive technologies may differ in how effectively they integrate with electronic health record platforms, as well as in their mode of deployment (e.g., locally installed vs. cloud-based access). These variations underscore the need to carefully evaluate integration options before finalizing and communicating an approved accommodation.

Device-based assistive technologies, such as recording devices, should also be thoroughly reviewed prior to implementation. Clear protocols must be established for the secure handling,

storage, and disposal of recorded materials to ensure compliance with institutional policies and privacy requirements.

Example Accommodation-Use of Recording Device During Patient Interactions

Student will utilize a HIPAA-compliant recording device during patient interactions in order to effectively capture necessary patient information required for charting. The recording device will be encrypted and secured within a site-identified location, and all recordings will be deleted at the conclusion of each clinical shift. [DRP/University should include device specifics and security protocols.]

Similar privacy concerns arise with electronic magnification devices. Although these devices are primarily used to view structures or information in real time, many also include recording functions. Accordingly, the accommodation should clearly outline protocols governing the use of any recording features.

Example Accommodation-Assistive Technology for Magnification Purposes

The student will utilize a HIPAA-compliant portable electronic magnifying device for visual enhancement purposes. [DRP/University should include specifics about the magnification technology and features required, which may include an option for the student to utilize their own accessible device (e.g., tablet/phone magnification applications, digital magnifier).]

Because of the risks associated with inappropriate disclosure of sensitive patient data, the use of these technologies should be carefully reviewed in collaboration with the clinical site, program administration, and the student.

One final example of assistive technology relates directly to a learner's disability management (see below).

Example Accommodation-Direct Access to Monitoring Device

The student must have direct access to condition-related monitoring device(s) at all times. When technology cannot remain with the student (e.g., during surgical procedures), a clear process must be established to ensure the student receives immediate updates or alerts regarding condition management in a discrete manner. [The program should specify the device(s) involved (e.g., smartphone, insulin pump). Some monitoring devices may require the use of a smartphone in airplane mode with Wi-Fi or Bluetooth enabled.]

Use of these devices is rarely contested; however, establishing protocol is essential to avoid surprises and prevent the student from having to explain their disability in the middle of a clinical activity. In cases where a monitoring device may interfere with clinical equipment, the accommodation should stipulate exemption from those environments. For example, individuals with insulin pumps may need to avoid exposure to MRI machines to ensure safety for both the student and the patient.

Location-Based Accommodations: Purpose and Communication

At first glance, “location-based” accommodations can be misunderstood. They are sometimes perceived as student preferences (e.g., wanting a closer commute or avoiding challenging sites), but their purpose is rooted in disability-related access needs. To avoid misinterpretation, programs should carefully distinguish between what belongs in the formal clinical accommodation letter and what should be managed through internal communication with clerkship placement coordinators and clinical sites.

Formal accommodation letters should generally reference the *type* of support (e.g., proximity to accessible transit, exclusion of inaccessible sites) without detailing every logistical element. Specifics—such as which sites are excluded, what transit routes are feasible, or how priority placement should occur—are best handled in confidential conversations among the DRP, program administration, and placement coordinators. This dual approach ensures clarity for site leaders while preventing students from having to justify their needs repeatedly.

Common Misconceptions and Clarifications

Misconception 1: Students just want to be closer to home or campus.

Reality: Proximity requests are not based on convenience or preference. Disability-related reasons may include chronic health conditions, mobility limitations, or psychological needs. Accommodations may require sites within a set parameter from the university or confirmation of accessible transportation options operating during clinical hours.

Example Accommodation – Clinical Placement Proximity/Access to Transit

Student requires clinical placements within [defined placement parameter] from the school of medicine. For placements outside this area, accessible public transportation operating during clinical shift hours must be confirmed in advance.

Misconception 2: Students request location-based accommodations because they lack a car.

Reality: Not owning a vehicle is not itself grounds for accommodation. However, if a disability prevents a student from operating a vehicle, it would make sense that they would not own a vehicle. The interactive process may determine that access to accessible alternatives (walking/biking distance, reliable public transportation, or reasonably priced ride share) is necessary to ensure access.

Misconception 3: Students avoid sites they perceive as too challenging or fast-paced.

Reality: All clerkship sites are demanding and theoretically provide equivalent experiences for core clerkships. Accommodation requests to exclude a site are determined via an interactive process to determine if there is a legitimate disability-related barrier at each site. Exclusions are often linked to medical necessity, physical inaccessibility, past treatment conflicts, or current treatment needs.

First, inaccessibility, often related to physical access, is a common reason to eliminate a site. Even if the site is technically compliant with access-related laws/requirements, physical access-related barriers may still exist. Therefore, clinical teams, in partnership with the university's DRP, should conduct reviews to eliminate inaccessible sites from the lottery process. If a site provides specialized training, exposure to a particular patient population, or unique procedural experience that interests the student, the student, clerkship director, and DRP should work together to assess the site and explore creative strategies for fostering inclusion.

Second, a student's disability-related treatment history may also warrant site exclusions. While medical programs typically have well-defined conflict of interest policies regarding students working directly with faculty, conflicts can arise from prior professional relationships—for example, when a student has previously received therapy from a faculty member. These conflicts may extend to entire sites. A student who has been hospitalized for a severe psychological condition, for instance, may have had contact with multiple providers at the same location (e.g., physicians, nurses, technicians). To minimize the risk of assessment bias in the student's clinical education, DRPs should consider excluding such sites from the lottery.

Third, current treatment-related needs could be related both to conflicts of interest and the need to be in close proximity to a specific location. Students with disabilities involving layered treatment needs (e.g., infusions, chemotherapies, physical therapy, etc.) are commonly connected with specialists. To ensure continuity of care, the student's clinical site location may need to be within close proximity to their home so that they can easily continue with treatments.

Example Accommodation – Clinical Site Exclusion

The following sites/locations must be excluded from the clinical placement lottery:
[University should list specific sites, with supporting rationale documented through the interactive process.]

Misconception 4: Students just want their first preference of clinical location.

While the ultimate proposed accommodation may result in a selection of a specific site, this occurs due to the inaccessibility of other sites and the inability to meet the students disability-related needs, even with the addition of other accommodations.

Example Accommodation: Priority Assignment/Placement for Clinical Experiences

Student requires a priority clinical assignment to be initiated in advance of the standard lottery placement process. *[DRP/University should work in collaboration with the student and clinical leadership to communicate specific accommodation/access-related needs in order to identify accessible clinical sites.]*

To ensure clarity around the need for specific site placements, DRPs should stay closely connected with clerkship teams. Site coordinators are constantly balancing multiple student needs within limited clinical placement options. By actively addressing common misconceptions and building awareness of the purpose and value of location-related accommodations, programs can foster a shared commitment to access and inclusion.

Scheduling

Many scheduling-related accommodations may appear straightforward—often aligning with existing clinical site procedures and even LCME Guidelines. In fact, some are so consistent with current practice that they might raise the question of whether they should be considered “accommodations” at all. Still, whether simple or complex, scheduling accommodations must be clearly communicated to ensure students’ disability-related access needs are met.

Importantly, while some are managed directly at clinical sites, many require proactive administrative implementation by clinical scheduling coordinators or leadership.

Leave Time for Disability-Related Appointments

A common example is *Leave Time for Disability-Related Appointments*. LCME Standard 12.4 requires that medical schools “provide students with timely access to necessary health services and policies that allow them to be excused from educational activities to seek care.” While this standard protects students, consistent or frequent appointments may draw questions from supervisors (e.g., “Why do you have so many appointments?”). This may be perceived as a professionalism issue, rather than a disability-related need. Therefore, DRPs should explicitly outline leaving for appointments as an accommodation, thus preventing unnecessary scrutiny.

Additionally, to ensure the university provides effective notice and awareness, an accommodation stipulating leave for appointments should include the frequency of appointments and outline specific protocols the student/clerkship team should follow to promote effective patient care handoff.

Example Accommodation – Student requires release time to attend disability-related appointments

[DRP/University should establish frequency of appointment needs, amount of time necessary for appointment leave (including transit time), and communication expectations. DRP should review accommodation implementation details with student/clinical leads (e.g., when/how should standing appointments be communicated).]

Rotation Schedule Continuity: Ensuring Consistent Access

An accommodation that often requires administrative coordination is Rotation Schedule Continuity. Some rotations—such as outpatient clinics or planned in-patient services—naturally lend themselves to stable scheduling, while others, like emergency-based rotations, may involve frequent or abrupt changes.

An example of an accommodation that requires administrative review/implementation is “Rotation Schedule Continuity”. Some sites (e.g., outpatient clinics, planned in-patient procedure sites, etc.) may naturally align with the ability to promote schedule continuity, whereas emergency-based rotations may not align as seamlessly.

Example Accommodation – Rotation Schedule Continuity

The student requires a consistent clinical schedule. When the clinical rotation requires a schedule change of an 8-12-hour difference (e.g., day shift adjusting to night shift), [insert number of days] should be provided between shifts. [DRP/University should identify the specific manner in which the consistency of a clerkship block is delivered based on the nature of the rotation and needs of the student]

The wording of this accommodation is intentional, setting clear parameters for when and how it applies. Instead of granting a blanket exemption from rotations with variable schedules, the language identifies the student’s specific need—a consistent clinical schedule—and provides solutions when schedule changes are inherent to the experience (e.g., allowing a defined adjustment period). The purpose of any disability-related accommodation is to foster access and inclusion. Schedule-based accommodations are therefore designed, approved, and implemented to ensure students can engage fully in essential learning opportunities, not to exempt them from acquiring the skills and knowledge integral to the rotation.

Accessible Approaches to Overnight Call Requirements

Some accommodations may involve exemption from specific non-essential program requirements. A common example is the requirement to complete an overnight shift. The intent behind this requirement is not to test a student’s ability to stay awake all night but to provide experience in environments that demand independent problem-solving with limited resources. In such cases, alternatives should be identified that achieve the same learning outcomes without the overnight component (e.g., weekend shifts, holiday shifts, or extended early morning/late evening shifts).

Example Accommodation-Alternative to Overnight Call/Shifts

Student requires [insert identified alternatives] in lieu of overnight call/shifts.
[DRP/University should specify appropriate/reasonable alternatives (e.g., working weekend/holiday shifts, early morning/late evening, etc.).]

Decompressed Clerkship Blocking

A final example of a scheduling-related accommodation is *Decompressed Clerkship Blocking*. This accommodation should be considered and planned far in advance of when a student begins their clerkship series. Importantly, decompression is not a “one-size-fits-all” solution. While adjusting the timing of clerkships may be reasonable, the way it is implemented depends on

factors such as curricular design, assessment structures, and programmatic competencies and standards.

For example, in a block-based curriculum, decompression may involve a block-on/block-off approach or extending the duration of individual clerkships to reduce intensity, while in a longitudinal curriculum, it may involve adjusting clinical exposure across a longer timeframe. The example provided here is only one of many ways this accommodation has been successfully accomplished, underscoring the need for programs to tailor solutions to their specific structure and the student's access needs.

Example Accommodation-Decompressed Clerkship Blocking

Student requires a decompression of clerkship block, which will adjust the standard length of clinical rotations. [DRP/University should specify type of decompression schedule (e.g., block-on/block-off, less time per day over more days, more days off per week, etc.) for each individual clerkship]

The implementation of this accommodation is complex and multi-layered, yet it has been successfully put into practice at multiple institutions through a variety of approaches. While some universities may have several options for decompression, others may only be able to implement it in one specific way. For programs that have not yet approved this accommodation and have concerns about its reasonableness, a fundamental alteration analysis—typically facilitated by the DRP—can help determine the most appropriate path forward while maintaining alignment with program standards.

Communication Access

Communication Access accommodations are designed to reduce or eliminate barriers for individuals with communication-related disabilities. While frequently associated with the needs of Deaf and Hard of Hearing students, they can also support individuals with conditions that affect speech (e.g., stuttering, Tourette's Syndrome). These accommodations provide alternative or adaptive methods for both expressing and receiving information. Common examples include sign language interpreters, Communication Access Realtime Translation (CART, or "real-time captioning"), written transcripts of audio recordings, captioned modules, videos and lectures, and communication aids such as visual supports or speech-generating devices.

Example Accommodation-Use of In-Person Communication Access Real-Time Translation (CART)

The student will utilize in-person CART services during clinical rotations, which will necessitate the use of a personal electronic device for display of captions. All CART providers have completed the necessary training and onboarding requirements for [insert health system/school] to facilitate access in clinical environments.

Communication access accommodations differ based on student needs, the type of clinical experience (e.g., clerkship, rotation, sub-internship), and the clinical site itself. To navigate this complexity, DRPs should engage early with institutional leadership, clerkship administrators, and site faculty and staff. These conversations not only clarify site-specific requirements but also provide opportunities to educate faculty about accommodation needs, surface concerns, and answer questions.

One recurring challenge involves the “clearance” process for sign language interpreters, CART providers, or communication technology, which can vary significantly across hospitals and clinics. In many cases, personnel must complete pre-employment credentialing and screening, which may include security clearances, proof of vaccination, background checks, or mandatory training. Certain technologies may also require approval from hospital compliance offices. By coordinating these steps in advance, DRPs can help prevent delays in student participation and strengthen partnerships with clerkship teams.

Communication Tip Sheets/Memos

While not an official accommodation, some students with communication-related needs may request a "Communication Tip Sheet/Memo" to accompany their accommodation letter. This concise document offers practical guidance for working with individuals with specific disabilities.

Although not an official accommodation, some students with communication-related needs may request a *Communication Tip Sheet or Memo* to accompany their accommodation letter. This brief document provides practical guidance for working effectively with individuals with specific communication disabilities.

For example, a student using ASL interpreters may wish to clarify that faculty and staff should address them directly rather than the interpreter. A student who stammers may want others to know that if they appear “stuck,” it is more supportive to pause than to finish their sentence for them. These tip sheets should be developed collaboratively with the student and kept

concise—ideally one page—to respect the time constraints of clinical faculty and increase the likelihood of engagement.

A communication tip sheet is included as an appendix to this guide (please refer to Appendix G.

Conclusion

This guide is intended to provide high-level, broad information on clinical accommodations and is not meant to be all-encompassing. The process of determining accommodations must always be individualized, interactive, and context-specific—shaped by the student’s needs, the requirements of the curriculum, and the realities of the clinical environment. The examples included here are meant to serve as reference points, not as a prescriptive list of solutions, and they should be applied with careful consideration to the facts of each case.

By approaching accommodations in this way, programs can create consistent and legally sound practices while remaining responsive to the complexities of clinical training. This work is not only about meeting compliance standards; it is about ensuring that MSWDs are able to participate and demonstrate their competence under equitable conditions.

Appendix A. Individualized Adjustment/Need

Accommodation Statement	Accommodation Description
<i>Sit or Stand, When Necessary</i>	Student requires the ability to periodically sit or stand during clinical activities. Student should be permitted to utilize a stool/chair as needed. [DRP/University should discuss protocol with the student for obtaining a stool/chair within sterile environments.]
<i>Access to Food/Drink</i>	Student requires periodic access to non-disruptive food/drink within the clinical setting. In a sterile or other clinical setting where food/drink is typically not allowed, the student should be given a safe place to store their food/drink where it may be quickly and easily accessed.
<i>Advanced Notice of Assigned Patients/Records</i>	Student requires the ability to arrive early for the shift to review patient/chart information. When students are not permitted/able to arrive prior to clinic opening, alternative options should be implemented (e.g., allowing the student to remain after their completed shift to review patient assignments/information for the next day, remote access to patient assignments, etc.). [DRP/University should include scheduling/access specifics.]
<i>Additional Time to Complete Patient Notes</i>	Student requires additional time outside of clinical hours to complete patient notes. [DRP/University should determine and specify the method of providing extended access (e.g., access to the clinical site before or after assigned hours, access to patient records through the use of a secure virtual private network (VPN) on an approved personal device, etc.).]
<i>Quiet Private Location for Breaks</i>	Student requires access to a private location for disability-related management purposes. Call rooms or administrative office locations may be appropriate, based on the nature of the clinical setting. [DRP/University should engage with the site to determine and clarify appropriate spaces.]
<i>Assistance with Manual/Physical</i>	Student requires assistance performing clinical tasks involving the act of lifting, pulling, pushing, and/or carrying items over ["X amount of weight"].

Accommodation Statement	Accommodation Description
<i>Tasks and Maneuvers</i>	[DRP/University will clarify specific physical restrictions with the student and discuss implementation with the clinical site.]
<i>Use of Additional Personal Protective Equipment (PPE)</i>	Student requires the following enhanced/additional personal protective equipment during patient interactions/procedures: [List specific PPE and associated clinical activity for which PPE is needed.]
<i>Access to Disability-Related Supplies</i>	Student requires proximate and unfettered access to disability-related supplies in a secure location. [DRP/University indicates any needs related to the type of location and supply storage needs (e.g., refrigeration, etc.).]
<i>Patient Assignment Exemption</i>	Student is exempt from caring for patients with a specific confirmed or suspected diagnosis of [insert specific diagnosis (e.g., Cystic Fibrosis, Tuberculosis, etc.).]
<i>Limited Adjustment to Attendance Expectations/Policies</i>	Student requires limited adjustment to attendance expectations/policies for pre-scheduled and unexpected absences. [DRP/University should establish frequency of absence-related needs and communication expectations surrounding both planned and unplanned absences. DRP should review accommodation implementation details with student/clinical leads (e.g., standard attendance expectations, amount of clinical hours that can be missed without compromising essential elements/competency attainment, when/how absences should be communicated, how clinical hours can be made up). DRP/University should also discuss protocol for addressing extended periods of absences, which would necessitate alternate measures (leave of absence, repeat of clinical experience, etc.).]
<i>Service Animal Notice</i>	Student will be accompanied by a service animal - an animal trained to perform specific tasks related to the student's disability and will remain under the student's control at all times. [DRP/University will review each environment, address any advance preparations that may be necessary to ensure the health and safety of others, and identify any environments where the animal may not be permitted (e.g., sterile environments, etc.). For environments in which the service

Accommodation Statement	Accommodation Description
	animal is not permitted, alternative accommodations will need to be explored and implemented.]
<i>Use of Sterile Cast/Brace Covering</i>	Student requires covering for cast/brace within environments requiring sterility. [DRP/University should indicate specific covering needs and the responsible party for provision.]
<i>Use of Non-Latex Gloves/Products</i>	Non-latex gloves should be provided/available within clinical environments when gloves are required.
<i>Allowance of Momentary Pause During Rounding/Bedside Teaching Questions/Answer</i>	Student requires a brief pause [insert specific range of time (e.g., “5-10 seconds”)] before communicating their response during rounding/bedside teaching.
<i>Uninterrupted Patient Presentation</i>	Student requires an uninterrupted style of patient presentation. Attending questions and/or comments should come after, not during, the presentation of patient information.
<i>Notes During Patient Presentation</i>	Student requires access to their personal notes during patient presentations.
<i>Use of Simulation Lab for Assessment of Skill/Procedure</i>	The following predetermined procedures/skills have been identified as suitable for simulated assessment and should be demonstrated/evaluated in a controlled, simulated environment (in lieu of direct patient interaction): [DRP/University to identify and outline specific skills/procedures].
<i>Avoid Exposure to Equipment/Devices</i>	The student must not be put in environments requiring the use of the following medical devices/equipment: [List specific environments/equipment]. [DRP/University must identify specific environments/equipment the student must avoid (X-Ray, MRI, etc.) and additional considerations (e.g., distance from devices,

Accommodation Statement	Accommodation Description
	protocol of communication when student must excuse themselves to avoid exposure, etc.).]
<i>Assistance with Gowning/Gloving</i>	Student requires assistance with gowning and gloving procedures. A developed procedure regarding necessary sterilization practices and an effective gowning/gloving protocol is available here: [DRP/University should provide specific protocol information].
<i>Use of Scribe</i>	Student requires a medical scribe to document patient-physician interactions in real-time and to record pertinent information into the patient's medical record.
<i>Enlarged Font on Printed Handouts/Documents</i>	Any hard copy/printed documents should be provided in an enlarged format. [DRP/University should indicate the required font size based on individual student needs.]
<i>Adjustments in Standardized/Typical Apparel</i>	Student requires an exception to the standard dress code policy. [DRP/University must provide specific exceptions (e.g., the use of a small-brimmed visor/hat, tinted eyewear, custom footwear/orthopedic shoes, or specified sizing for scrub tops/bottoms).]
<i>Use of Qualified Intermediary</i>	The student will be accompanied by a qualified intermediary/assistant, who will provide support on non-competency-bearing clinical duties (e.g., assisting with patient positioning/maneuvers during examinations, obtaining supplies, etc.). All intermediaries/assistants have completed the necessary training and onboarding requirements for [insert health system/school] to facilitate access in clinical environments. [DRP/University should identify and provide examples of what skills/tasks the intermediary will/will not provide support/assistance for.]
<i>Use of Personal Mobility Device</i>	Student will utilize a personal mobility device. [DRP/University should specify which device will be used (e.g., manual/power wheelchair, scooter, Segway, etc.).]

Appendix B. Adaptive Equipment

Accommodation Statement	Accommodation Description
<i>Use of Noise Reducing Ear Plugs when Charting</i>	Student may utilize a noise-reduction device (in- or over-ear) to minimize environmental distractions while reviewing/documenting patient information and interactions. [DRP/University should include device specifics.]
<i>Use of Magnification Glasses</i>	Student may utilize magnification glasses to enhance visual elements during clinical duties (e.g., Surgical Loops, Monocular Lens, etc.). [DRP/University should include device specifics.]
<i>Use of Portable Stool</i>	Student will carry and utilize a personal portable [indicate type of stool] stool during rounds and clinical duties. [DRP/University will need to indicate whether this is a seated stool or step stool. They will also need to indicate what environments the stool cannot be utilized in (e.g., OR, secure units, etc) and what alternatives should be provided within these settings.]
<i>Access to Stool/Chair in Sterile Environments</i>	Student requires the ability to periodically sit or stand within sterile environments and requires access to a stool/chair while maintaining the sterile field. [DRP/University should discuss protocol with the student for obtaining a stool/chair within sterile environments.]
<i>Use of Adaptive Furniture for Clinical Duties</i>	Charting workstations must be equipped with the following adaptive furniture: [List specific adaptive furniture]. [DRP/University should include device specifics (e.g., adjustable lumbar support, raising armrests, tilting features, height-adjustable workstations/tables, etc.). DRP/University must also discuss a process of inclusion for the student in the event a workstation with adaptive technology is not currently available in the

Accommodation Statement	Accommodation Description
	clinical team's workroom (e.g., how to obtain the appropriate equipment, other locations the team may be moved to for group work/discussion, etc.), as the student should not be separated from the rest of the team for the purposes of their accessibility.]
<i>Use of Adaptive Medical Devices</i>	Student requires use of the adaptive medical devices [List Devices (e.g., plastic speculums, spring-action scissors, etc.)]. Adaptive medical devices should be provided within procedural environments and easily accessible in the student's clinical space. [DRP/University should determine appropriate adaptive devices and who will supply (e.g., student, faculty, site, etc.).]
<i>Use of Finger Splints</i>	The student will utilize finger splints during patient evaluations and procedures. [DRP/University should discuss and implement alternative accommodations for procedures that, due to the sensitive nature of the exam, may require alternative devices/approaches.]
<i>Use of Grip Enhancements for Medical Tools</i>	The student will utilize gripping materials, such as foam tubing, on handheld instruments (scalpels, reflex hammers, tuning forks, etc.), to enhance handle size and increase the friction of surface area. [DRP/University should determine appropriate grip enhancements with the assistance of the clinical site/rotation director and determine whether the institution, student, or site will purchase/provide.]
<i>Use of Texturized Surgical Gloves</i>	Student requires texturized surgical gloves for all clinical learning opportunities involving the use of surgical gloves. [DRP/University should determine the type of texturized surgical glove (e.g., Microflex gloves, Dynarex Sterile Latex Surgical Gloves, Ansell Gammex Non-Latex PI Ortho, etc.).]

Accommodation Statement	Accommodation Description
<i>Use of Draping/Covering</i>	Student requires the use of protective draping/covering for disability-related equipment or accessories. [DRP/University should determine appropriate covering based on student need/environment and the responsible party for purchase (e.g., draping for mobility devices armrest/joystick, assistive technology, covering for oxygen concentrators, etc.).]
<i>Use of Amplified Stethoscope</i>	Student will utilize an amplified stethoscope during all clinical interactions in which a traditional unmodified stethoscope is necessary.
<i>Use of Adaptive Stethoscope with Visual Display</i>	Student will utilize an adaptive stethoscope that includes a visual display during all clinical interactions in which a traditional unmodified stethoscope is necessary.
<i>Use of Butterfly Needles</i>	The student will require access to butterfly needles when conducting blood draws. [DRP/University should specify the situation in which butterfly needles are necessary.]
<i>Use of Glove Liners</i>	The student requires the use of glove liners within clinical environments.
<i>Use of Adaptive On-Call Room Equipment</i>	The student requires visual and/or tactile alternatives to auditory alert systems. [DRP/University should specify alert system needs (e.g., flashing lights, bed shaking devices, etc.).]
<i>Use of Elevation Prop</i>	The student will utilize a prop during patient evaluations. [DRP/University should specify prop (e.g., stool, cushion, pillow, etc.) and usage (e.g., how the student utilizes prop throughout patient evaluation).]

Appendix C. Assistive Technology

Accommodation Statement	Accommodation Description
<i>Assistive Technology for Magnification Purposes</i>	The student will utilize a HIPAA-compliant portable electronic magnifying device for visual enhancement purposes. [DRP/University should include specifics about the magnification technology and features required, which may include an option for the student to utilize their own accessible device (e.g., tablet/phone magnification applications, digital magnifier, etc.).]
<i>Use of Assistive Technology at Charting Workstations</i>	Charting workstations must be equipped with the following adaptive technology(ies): [List specific assistive technologies]. [DRP/University should include device specifics (e.g., large monitor, ergonomic keyboard/mouse, etc.).] DRP/University must also discuss a process of inclusion for the students in the event a workstation with adaptive technology is not available in the clinical team's workroom (e.g., how to obtain the appropriate equipment, other locations the team may be moved to for group work/discussion, etc.), as the student should not be separated from the rest of the team for the purposes of their accessibility.]
<i>Use of Laptop/Tablet with Accessibility Features for Documentation Purposes</i>	Student will require the use of a laptop/tablet with accessibility features for the purpose of documenting patient/client interactions. In the event that required accessibility features are not present or cannot be added, appropriate and effective alternatives should be provided. [DRP/University should include specifics about the accessibility software and features required, which may include an option for the student to utilize their own accessible device.]

Accommodation Statement	Accommodation Description
<i>Use of Text-to-Speech Software</i>	Student will utilize text-to-speech software to access electronic text. [DRP/University should identify and implement text-to-speech software compatible with the clinic site's secure systems.]
<i>Use of Screen Reader Technology</i>	Student will utilize screen reader software to access and complete reading-based clinical activities/duties. [DRP/University should identify and implement screen reader software compatible with the clinic site's secure systems.]
<i>Use of Headphones/Earbuds While Accessing Digital Materials</i>	Student will utilize either wireless or corded headphones/earbuds while navigating digital platforms in order to access screen reader/text-to-speech software.
<i>Use of Speech-to-Text Dictation Software for Charting/Noting Purposes</i>	Student will utilize dictation software for notes/charting purposes, and must have access to charting stations equipped with dictation software. [DRP/University should identify/implement compatible dictation software.]
<i>Use of Recording Device During Patient Interactions</i>	Student will utilize a HIPAA-compliant recording device during patient interactions in order to effectively capture necessary patient information required for charting. The recording device will be encrypted and secured within a site-identified location, and all recordings will be deleted at the conclusion of each clinical shift. [DRP/University should include device specifics and security protocols.]
<i>Direct Access to Monitoring Device</i>	The student must have direct access to condition-related monitoring device(s) at all times. In instances where technology must be kept separate from the student (e.g., during surgical procedures), an effective process must be developed to ensure the student receives immediate updates/alerts regarding condition management/needs in a discrete manner.

Accommodation Statement	Accommodation Description
	[DRP/University should include device specifics (e.g., smartphone, insulin pump, etc.). The monitoring device may require the use of a smartphone in airplane mode with Wi-Fi/Bluetooth enabled technologies.]
<i>Use of Electronic Otoscope</i>	The student will utilize an electronic Otoscope with a fiberoptic camera for patient evaluation/examination.

Appendix D. Location

Accommodation Statement	Accommodation Description
<i>Pre-Exposure to Clinical Site</i>	Pre-exposure to an assigned clinical site should be permitted sufficiently in advance for the student to orient themselves to the site, familiarize themselves with the environment, and identify any potential disability-related access barriers that may require additional accommodations.
<i>Clinical Site Exclusion</i>	The following sites/locations must be excluded from the clinical placement lottery process: [DRP/University should list specific sites to be excluded and associated follow-up conversation with placement coordinator.]
<i>Clinical Placement Proximity/Access to Transit</i>	The student will require clinical placements within [a defined placement parameter] from the School of Medicine. For placements outside this area, accessible public transportation that operates during the student's clinical shift hours must be confirmed in advance.
<i>Priority Assignment/Placement for Clinical Experiences</i>	Student requires priority clinical assignment, to be initiated in advance of the standard lottery placement process. [DRP/University should work in collaboration with the student and clinical leadership to communicate specific accommodation/access-related needs in order to identify accessible clinical sites.]
<i>Physically Accessible Clinical Site</i>	Student requires physically accessible clinical site(s), which should include [list specific requirements based on student need]. [DRP/University will communicate specific needs for physical accessibility with clinical leadership and determine site accessibility, then make recommendations for excluding non-accessible sites from the selection process.]

Appendix E. Scheduling

Accommodation Statement	Accommodation Description
<i>Release Time for Disability-Related Appointments</i>	Student requires release time to attend disability-related appointments. [DRP/University should establish frequency of appointment needs and amount of time necessary for appointment leave (including transit time), communication expectations. DRP should review accommodation implementation details with student/clinical leads (e.g., when/how should standing appointments be communicated).]
<i>Pre-Scheduled Breaks</i>	Student requires a [insert duration (e.g., 5-10 minutes)] break every [insert frequency (e.g., 2 hours)]. [DRP/University should include specific break needs for each clinical rotation and indicate if these breaks are in addition to any provided lunch break.]
<i>Unscheduled Periodic Breaks</i>	Student may require brief breaks [insert duration (e.g., 5-10 minutes)], break up to [insert number of times per shift], in addition to any provided lunch break. [DRP/University should establish the frequency of potential breaks and review accommodation implementation details with student/clinical leads. DRP/University should also discuss protocol for addressing extended breaks that impact consistency of patient care, which would necessitate alternate measures (e.g., absences in lieu of breaks, leave of absence/repeat of clinical experience in the event significance of frequency infringes upon student learning/competency attainment, etc.).]
<i>Decompressed Clerkship Blocking</i>	Student requires a decompression of clerkship block, which will adjust the standard length of clinical rotations.

Accommodation Statement	Accommodation Description
	[DRP/University should specify the type of decompression schedule (e.g., block on block off, less time per day over more days, more days off per week, etc) for each individual clerkship.]
<i>Alternative to Overnight Call/Shifts</i>	Student requires [insert identified alternatives] in lieu of overnight call/shifts. [DRP/University should specify appropriate/reasonable alternatives (e.g., working weekend/holiday shifts, early morning/late evening, etc.).]
<i>Rotation Schedule Continuity</i>	The student requires a consistent clinical schedule. When the clinical rotation requires a schedule change of an 8-12-hour difference (e.g., day shift adjusting to night shift), [insert number of days] should be provided between shifts. [DRP/University should identify the specific manner in which the consistency of a clerkship block is delivered based on the nature of the rotation and needs of the student.]
<i>Priority Clerkship Ordering</i>	Student requires the following sequence for clerkship ordering [insert necessary clerkship order/parameters]. [DRP/University must identify specific parameters (e.g., should not begin with an 8-week rotation, must/must not begin with “X” rotation, etc.).]
<i>Designated Off Hours</i>	Student requires [Insert number of hours/days] off between the conclusion and start of clinical shifts.

Appendix F. Communication Access

Accommodation Statement	Accommodation Description
<i>Use of Assistive Listening Device</i>	Student will utilize an assistive listening device within clinical settings. The listening device will require the primary speaker (e.g., attending, resident, patient, etc.) to wear or be within close proximity to a lapel microphone, which will transmit audio directly to the student's personal device. [DRP/University should specify what listening device (FM System, Pocket Talker, Roger On iN, etc.) will be used and provide guidance to clinical teams.]
<i>Use of Microphone During Lecture-Based Clinical Activities</i>	To facilitate effective audio access, the use of a microphone is required for all speakers during lecture-based clinical activities, including individuals asking questions or making comments.
<i>Closed Captioning of all Media-Based Materials</i>	All pre-recorded videos, including recorded lectures, podcasts/vodcasts, and previously recorded media used in clinical instructional activity, must be accurately captioned before posting or sharing with participants. [DRP/University must discuss captioning protocol and accuracy requirements with clinical leadership.]
<i>Transcripts of all Media-Based Materials</i>	Transcripts should be provided for all pre-recorded videos, including recorded lectures, podcasts/vodcasts, and previously recorded media. Media materials used throughout clinical instructional activity must be accurately transcribed before posting or sharing with participants. [DRP must discuss transcription protocol and accuracy requirements with clinical leadership.]

Accommodation Statement	Accommodation Description
<i>Use of Remote Communication Access Real-Time Translation (CART)</i>	The student will utilize remote CART services during clinical rotations. To ensure effective translation, the student will utilize both an electronic tablet (to review captions) and a Bluetooth mic, which should be worn by (or be in direct proximity of) the presenter. CART providers have been vetted and cleared through University procedures and are held to the same confidentiality and privacy standards as the student.
<i>Use of In-Person Communication Access Real-Time Translation (CART)</i>	The student will utilize in-person CART services during clinical rotations, which will necessitate the use of a personal electronic device for display of captions. All CART providers have completed the necessary training and onboarding requirements for [insert health system/school] to facilitate access in clinical environments.
<i>Advanced Provision of Presented Materials</i>	All presentation materials (PowerPoint slides and other visual materials), including handouts, must be provided to the student in advance (24-hour minimum).
<i>Access to American Sign Language (ASL) Interpreters</i>	An ASL Interpreter will be present in the clinical environment, arranged through Disability Resources. The physical setup should allow a clear line of sight between the student, interpreter, clinical instructor/patient, and any materials presented. Sign Language Interpreters are vetted and cleared through university procedures and adhere to the same confidentiality and privacy standards as the student. [DRP/University to clarify whether interpreters will be in-person or virtual and ensure appropriate set-up of service.]
<i>Use of Clear Face Masks</i>	Clear masks - FDA-cleared (CLASS II) and ASTM Level 3 – 432/CS - should be utilized by individuals interacting with the student to allow for lip reading and facial referencing during communication. [DRP/University should work with the clinical site to determine distribution and access to clear masks/]

Accommodation Statement	Accommodation Description
<i>Rounding in Quiet Location</i>	Unless addressing an urgent concern, clinical instruction and rounds should take place in a quiet space (e.g., patient room, conference space), rather than hallways or other busy spaces.
<i>Access to Video Phone, Video Relay Service, or Internet Protocol Relay</i>	Adaptive phone system (e.g., video phone, video relay service, or internet protocol relay) must be available on-site to perform phone-based clinical duties. [DRP/University should determine an appropriate alternative phone system and coordinate with the clinical site.]
<i>Use of Vibrating Text-Based Pager</i>	University will provide the student with a vibrating text-based pager device.



Appendix G. Clinical Experiences

Tips for Communicating with Deaf and Hard of Hearing Medical Students

How do I interact with a student who is Deaf or Hard of Hearing (DHH)?

When possible, make eye contact and speak directly to the student. The DHH learner uses designated sign language interpreters ([DLI](#)) for communication and will sometimes utilize lip reading as a secondary modality.

How will the student access information during didactics/presentations?

DHH students utilize various accommodations, and often combine accommodations to optimize both acoustic and visual access simultaneously. They may provide Bluetooth microphones to the speaker or for the table or use T-coil in looped auditoriums. They may also use real-time captioning (also known as CART) with or without the presence of specialized sign language interpreters.

How can you make the environment more accessible?

Repeat questions or other communications from the audience. While this is especially relevant if you are wearing a microphone to amplify your voice, all students can benefit from the clarity this provides.

If you, or other students, will be wearing masks in this environment inquire about using [clear masks](#) that allow the student to still be able to read lips and see who is speaking.

Standardized Patient/ Clinical Encounters?

Interpreter will place themselves slightly besides or behind the patient to prevent distractions between DHH learner and their patient. SP will speak directly to DHH learner as opposed to saying things to the interpreter such as “tell him”

How to Avoid Misunderstandings

Show then tell, or vice versa – not simultaneously to prevent student from missing information while watching the interpreter for instruction.

Example: DO: Pause your lecturing while writing on the white board or pointing something out in lab, exam, lecture, etc

DON'T: Continue your explanation while facing away from the audience, obscuring your face

Do: “You should go to the splenectomy at 11, and make sure you meet the patient in pre-op before you scrub in.” **Don't:** “If you want to see a splenectomy you can scrub in, but you should probably meet the patient in pre-op before.”

Directives are important. Clearly state when, where, and how you would like the student to perform an activity – this is critical information. We advise everyone to be goal-directed and concise rather than use implicit language.



Teaching Tips:

Hands on procedures/surgery:

During non-urgent hands-on procedures please explain the process first, and then demonstrate. This allows the student to have his full attention on the procedure and not the interpreter. In some cases, guiding his hands manually with yours can be very effective.

Operating Room/Patient Isolation:

The interpreters will use [clear masks](#) so that the student can access mouth movement and sign language grammatical markers on the face. We encourage other medical professionals to use them as well where comfortable and appropriate. The interpreter may supply the surgeon with a small Bluetooth mic in lieu of being in the sterile zone to hear better.

Auscultation:

Many DHH learners use highly specialized stethoscopes to enhance their ability to hear heart and lung sounds. These work by amplifying sounds, using Bluetooth to directly stream to the learner's listening device, and/or providing a visual representation of the auditory input.

Codes/Trauma/Critical Care:

The interpreter will position themselves in the best site line for the DHH learner during rapid response needs. Care and procedures will continue to be uninterrupted while performing tasks that require simultaneous visual and audio instruction.

Phone Calls:

Interpreters will translate using a headset or some modification to the phone system.

Reading Room Environments:

Since the dark room makes it difficult to read lips, students will often rely more on interpreters to access information who may use a light on their face. Looking at two places at once poses a problem for tracking conversations. When possible, point to specific details on computer images and then begin your explanation after indicating the point of reference.

Is there anything to be aware of when working with interpreters?

All of our interpreters adhere to a Code of Professional Conduct and are HIPAA trained. Interpreting is not instantaneous; there may be some lag time. We recommend taking a brief pause after asking questions to allow the DHH time to process the fully interpreted message. At times the student will have debriefs with their interpreter in sign language regarding logistical, linguistical and team feedback. These conversations help clarity in communication; they are not meant to be exclusive of others.

Appendix H. Example Clinical Accommodations Letter

To: School of Medicine Clerkship Director/Coordinator/Supervisor

From: DRP/Point of Origin

Regarding: Disability Accommodations for [Student]

[Date]

This letter confirms that [Insert Student Name] is registered with Disability Resources and approved for clinical accommodations. Eligibility and specific accommodations are determined individually based on the student's documented needs in the academic and clinical settings. Disability Resources collaborates with the student and program to ensure access while maintaining all essential program requirements.

[School of Medicine] is committed to an inclusive learning environment. Accommodations help remove barriers to full participation, and clinical instructors are key partners in putting them into practice. Disability Resources is available to support both faculty and students throughout this process.

Although [name of office] initiates communication about approved accommodations, additional discussion between faculty and the student may be necessary to address implementation details in particular rotations.

Approved Accommodations:

After a thorough review of disability-related information, [Student Name] has been determined eligible for the following accommodations:

Clinical Access

- **Example Accommodation - Periodic Breaks:** Student may need periodic breaks throughout daily rotation to address disability-related needs. In general, student may require short breaks (10-15 minutes) up to 4 times per day (number of breaks will vary based upon the nature of the clinical setting and hours worked. Given the chronic nature of the student's disability, they may not require the use of this accommodation every shift; however, during flares, student may require emergent, frequent breaks (aligned with the parameters detailed above). Student and Clinical Supervisor should discuss the implementation of breaks and what communication/notification is necessary in the event a break is needed to

ensure breaks do not interfere with patient care/safety or other essential clinical obligations.

- **Example Accommodation - Use of Stool/Seating, as Needed:** Student may need to periodically sit during clinical rotations to address disability-related needs. During clinical activities involving stagnant standing (e.g., surgical/procedural observations) persisting for longer than 45-60 minutes, access to a stool may be intermittently necessary. In non-surgical/sterile environments, student will utilize a personal collapsable stool provided by the University.

If you have any questions or concerns about the accommodations listed above, please don't hesitate to contact our office.

Thank you for your partnership in fostering an accessible and inclusive learning environment for all students.

All the Best,

Disability Resources

[Insert Additional Contact Information]