DAKOTA STATE
OFFICE OF DISABILITY SERVICES

Meal Plan Accommodation / Exemption Request

Before You Begin: Important Notes

To help ensure a smooth and timely review of your request, please read the following before completing this form.

1. **Deadlines**
    a. **Fall Semester:** Friday following the first day of classes
    b. **Spring Semester:** Friday following the first day of classes
    Requests received after these deadlines will be reviewed for the following semester unless a new medical or disability-related need arises mid-term.
2. **Required Documentation**
    c. Requests based on **medical needs** must include the **Physician's Form** completed by a licensed medical provider (MD, DO, NP, or ND).
    d. Requests based on **religious observance** must include the **Religious Leader Form** with a supporting statement and contact information.
    e. Correspondence from chiropractors, herbalists, or other non-licensed providers cannot be accepted.
3. **Important Process Details**
    f. Exemptions are granted **only when Dining Services cannot meet documented medical or religious needs**.
    g. All meal plan charges remain valid until a decision is communicated; approved exemptions are **prorated from the approval date**.
    h. Students must **reapply each academic year** with documentation dated within the past six months.
    i. False or misleading statements may result in disciplinary action under the Student Code of Conduct.
4. **Next Steps**
    j. Completed forms should be submitted through **Accommodate** or emailed to **dsu-ada@dsu.edu**.
    k. The student must meet with the **Campus Dietitian** before a decision can be finalized.

For the full set of guidelines, policies, and FAQs, please visit:

https://dsu.edu/student-life/disability-services/

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Student Information

First Name:_____Last Name:_____

DSU ID#: _____DSU Email: _____

Phone Number:_____ Current Meal Plan: _____

Your Class Year:_____

Describe why you are request a meal plan exemption/accommodation. Please provide specific information:

Phone number and name of religious leader: _____

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Authorization

Please mark each box beside each of the following items and sign below to indicate your understanding.

I am requesting:

☐ Meal Plan Exemption

☐ Other:

I authorize Dakota State University to receive information from my care provider in order to verify my need for a meal plan exemption. I also authorize my care provider to discuss my condition, if necessary, with appropriate Dakota State personnel.

I authorize Dakota State University to share my documentation with the Sodexo Dietitian, and I understand that I must meet with the dietitian before a decision can be made on my request.

By signing below, I affirm that all personal statements are true and accurate. I understand that falsifying or misrepresenting facts or information may result in disciplinary action.

Student Signature: _____

Date: _____