



Disability Services APPLICATION



Name: _____
Last First M.I.

Student No: _____

Address: _____

Date of Birth: _____

City State Zip

Local Phone: _____

Email Address: _____

Cell Phone: _____

Major: _____

Academic Advisor: _____

Minor: _____

Current Status: First Year Sophomore Junior Senior Grad Student
Transfer

Date Entered JMU: _____

Anticipated Graduation Date: _____

WHEN WILL THE OFFICE OF DISABILITY ACCOMODATIONS NEED TO START?

Fall Spring Summer, Year 20__

HOW DID YOU LEARN ABOUT OUR SERVICES?

<input type="checkbox"/> Access Syllabus Statement	<input type="checkbox"/> College Staff	<input type="checkbox"/> Orientation
<input type="checkbox"/> Adult Rehabilitation Agency	<input type="checkbox"/> High School Staff	<input type="checkbox"/> Website
<input type="checkbox"/> Another Student	<input type="checkbox"/> Literature	<input type="checkbox"/> Other
<input type="checkbox"/> College Instructor	<input type="checkbox"/> Parent	

DISABILITY: Check all that apply.

<input type="checkbox"/> Acquired Brain Injury	<input type="checkbox"/> Development Disability	<input type="checkbox"/> Orthopedic Impairment
<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Health Impairment	<input type="checkbox"/> Psychiatric Disability
<input type="checkbox"/> Blind/Visual Impairment	<input type="checkbox"/> Language Impairment	<input type="checkbox"/> Speech Impairment
<input type="checkbox"/> Deaf/Hard of Hearing	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Other (please specify)

Is the above condition: Permanent/Chronic/Unknown Temporary

Note: If your medical condition is not permanent in nature, the university is not required by law to provide any accommodation, but ODS may be able to assist you on a temporary basis.

Name: _____ Student ID# _____ p.2

ACCOMODATIONS:

Based on your disability, check the accommodations you believe you will need in college in order to have equal access. (Accommodation approval is based on supporting documentation of disability.)

<u>Instructional</u>	<u>Testing</u>	<u>Support</u>	<u>Environment</u>	<u>Equipment</u>
_Braille	_Alternate Format	_Interpreter	_Accessible Site	_Adapted Computer
_Disability Related Absence	_Calculator	_Lab Assistant	_Adjustable Table	_Amplified Phone
_Large Print	_Computer/Word Processor	_Note taker	_Preferential Seating	_CCTV
_Spelling Accommodation	_Distraction Reduced Site	_Personal Care Assistant*	_Space for Wheelchair	_Closed Captioning
_Tape Record Lectures	_Extended Time	_Reader	_Special Seat	_Listening Device
_Textbooks in Alternate Format	_No Scantron (Bubble Sheets)	_Support Animal*	_Paratransit	_Low Vision Aids
	_Reader	_Writer/Scribe		_Spelling Checker
	_Writer/Scribe	_Wheelchair*		_TTY/TDD

*** NOTE: personal devices, equipment and assistance will NOT be PROVIDED BY JMU, but require arrangements in some circumstances. Please list any such requirements.**

Other: _____

If you are registered with Virginia Rehabilitative services, **please check all appropriate boxes and complete a consent form** to allow exchange of information between Disability Services and Rehabilitative Services.

- Registered with Department of Rehabilitative Services
- Registered with Department for the Deaf and Hard of Hearing
- Registered with Department for the Blind and Visually Impaired

Disability Services must receive this form and **appropriate documentation of your disability to support requested accommodations prior to consideration and provision or approval of accommodations.** Once documentation is received and reviewed, the applicant will need to meet with Disability Services office staff to discuss accommodations, procedures, and policies. Information regarding disability is kept in Disability Services and is considered an academic record but is not noted in any way on the student's transcript.

Please note that ODS will exchange information with other relevant authorities on campus to evaluate and facilitate the provision of accommodations, and by signing this form, you are signifying your knowledge of and agreement with this practice.

The clinician who will prepare documentation is
(Please print name): _____
Address: _____
Phone: _____ FAX: _____

As indicated by my signature below, permission is granted to ODS to exchange information with this clinician as necessary to answer questions about the documentations submitted to support this request and in consideration of my application for accommodations.

Student Signature: _____ Date: _____