

EDUCATIONAL INFORMATION:

Are you interested in receiving services from local agencies?:

Vocational Rehabilitation Badlands Veterans

Other _____

What is your degree goal? Associates Bachelors Masters Other

What is your estimated graduation date? _____

Major: _____ Minor: _____

Name of academic advisor: _____

AREAS OF NEED In what areas do you feel you need assistance? Please be sure to circle all the services you would use.

Math Tutoring Science Tutoring Computer Science Tutoring
English/Composition Tutoring Academic Planning (Registration/Scheduling)
Testing Note Taking Audio Books/Alternate Formats Other

Describe the issues that you are experiencing in your class(es), housing, or other campus setting that may require accommodation(s):

The following reasonable accommodation(s) are requested in order to perform the essential academic functions as a student at DSU:

Authorization for release of information relating to disability accommodation(s):

I hereby authorize _____ (physician, psychologist, psychiatrist, educational diagnostician, other) to release any information requested on this form. By signing this form, I understand that once this request for accommodation(s) is processed, I may be required to provide additional documentation, on a case-by-case basis, of changes in my condition. I fully understand that this request for accommodation(s) is based on DSU's need for documentation to support my request for services.

I understand that DSU has no obligation to provide services until appropriate documentation has been received by the appropriate office handling the accommodation function on my campus. I further understand that services may be discontinued should documentation not be received within thirty (30) days of receiving temporary services (unless there are extenuating circumstances). I authorize DSU officials (such as staff providing disability accommodation services, Vice President for Student Service or Student Affairs, Executive Vice President/Provost, General Counsel, Office of Institutional Equity Executive Director, Student Health Center Director etc.) to: verify, discuss, transmit, or release on a "need to know basis only", the contents of this request form with my physician, psychologist, diagnostician, practitioner, and/or other authorized DSU personnel. This document will be treated as a confidential medical record. I, the undersigned, authorize the staff providing disability accommodation services to contact relevant DSU system disability services staff to share information pertaining to my accommodation(s) for the purpose of coordinating appropriate services and determining any necessary and reasonable academic adjustments.

I understand that it is my responsibility, as a Dickinson State University Student, to register each semester with the Disability Services Office to receive accommodations as a student with a disability.

Student Signature	Date

7/20/2015