Request for Disabilities Services

Please provide all of the information requested in order to enable your home university to best meet your needs. If you need assistance completing this form, please contact your primary university's disabilities services provider. **This form is available in taped and large print formats upon request.**

Date_____________

Name ____ SSN_______________________________

Current Address ____

Phone Number ______________________________ TDD Phone _______________________________________

Fax Number _________________________________ E-Mail Address ____________________________________

Please check each item that applies:

______ Applying for Admission/Accepted for Next Semester

______ Freshman
______ Sophomore
______ Junior
______ Senior
______ Graduate Student
______ Other (Please specify.)

Academic Major ________________________________ Referred by _____________________________________

Please list the names, addresses and phone numbers of each of your current physicians, therapists, counselors or other support services providers below. Indicate the person's role (e.g. Mary Smith, speech therapist, 123 East 4th St, Rapid City 605-555-6789)

____

____

____

____

Do you receive assistance from Vocational Rehabilitation or Services for Visually Impaired?
______ Yes ______ No

If yes, please indicate the name, address and phone number of your VRISVI Counselor.

____

____

Disability type: (please check all that apply)

______ Hearing	______ Speech
______ Vision	______ Mobility
______ Learning Disability	______ Attention Deficit Disorder
______ Neurological Condition	______ Respiratory Condition
______ Psychological/Psychiatric Condition	______ Other (Please describe.)

Are you taking any medication for the above conditions? ______ Yes ______ No

If yes, how will this medication affect your coursework?

____

____

____

____

Did you receive support or special services for disabilities while in high school? ______ Yes ______ No

If yes, please describe. ____

____

____

____

If possible, please fax or have a copy of your most recent Individualized Education Plan sent to your primary university.

Please check all of the adaptive equipment you use on a regular basis:

______ Cane	______ Communication Board
______ Lap Board	______ Hand Splints
______ Head Pointer	______ Lift-Equipped Van
______ Transfer Equipment	______ Assistive Speech Device
______ Laptop Computer	______ Tape Recorder
______ Magnification Equipment	______ Talking Equipment
______ Speech Transmission Device	______ Power Wheelchair
______ Manual Wheelchair	______ Other (Specify)
______ Crutches	

Have you been or are you frequently unable to complete coursework/assignments on time?
______ Yes ______ No

All students are required to provide medical or other appropriate diagnostic evaluation of their disability. Documentation must be provided by a qualified physician, psychologist, psychiatrist, rehabilitation specialist or other appropriate health care provider. Documentation must include, as appropriate, physical description, medical or clinical cautions and recommendations for necessary accommodations in an academic setting.

Statement of Agreement:

I understand that the staff of disabilities services may have access to my file, as well as academic and other university records in order to provide me with the support services I need. I further understand that in order to meet my educational needs, it may be necessary for the disabilities services office to provide recommendations for accommodations to faculty and facilities. I understand that it is my responsibility to notify my home university's disabilities services provider of any change in my medical status or special needs.

By completing this form, I consent to such disclosures, except that I do not want the following persons/offices to receive personal information about my disability:

____

____

____

____

For purposes of distance education courses offered from other South Dakota regental universities, please sign consent for the disabilities services providers to exchange information.

I give my signed consent for the disabilities services providers to exchange information to better serve me.

____

Signed Date

Please return this form with appropriate documents to your primary university.