SELF-DISCLOSURE & ACCOMMODATION REQUEST FORMS

Any student wishing to voluntarily self-disclose as having a disability and request accommodations should complete the form below. All information provided, including documentation submitted to substantiate your disability, will be kept confidential. Please note that reasonable accommodations may not be implemented retroactively, so being timely in requesting accommodations is very important.

PERSONAL INFORMATION

Date: ______________________ Student #:_________________________________

Name: ____

Address:____

City/State/Zip: ____

Date of Birth: ____________________ Ethnicity/Primary Language: ________________________

Baptist Email Address: ____

Phone: _________________________ Can a message be left at this number? Yes No

Student Status: ___ Current BHSU Student ___ Transfer/Incoming Student

Area of Study/Program: ____

Class Standing: ___ Freshman ___ Sophomore ___ Junior ___ Senior ___Graduate (DNP)

___ OMS-1 ___ OMS-2 ___ OMS-3 ___ OMS-4

Term requested accommodation to begin: ___ Fall ___ Spring ___ Summer

Emergency Contact:____

Name *Relationship*

Emergency Contact Phone: ____________________________

I give the ADA Coordinator permission to contact my emergency contact should they determine that an emergency situation exists.

____ ______________________________

Signature Date

DISABILITY INFORMATION

Nature of Impairment: (Check all that Apply)

___ ADHD

___ Learning Disability

___ Autism Spectrum Disorder

___ Medical/Physical Impairment

___ Head Injury/TBI

___ Psychological Impairment

___ Deaf/Hard-of-Hearing

___ Visual Impairment

___ Other (Please Specify)_____________________________________

What is the name of your specific disability as diagnosed by your health care provider?

What accommodations are being requested <u>for the classroom setting</u>? (Please be specific)

What accommodations are being requested <u>for tests and/or quizzes</u>? (Please be specific)

What accommodations are being requested <u>for labs or clinics</u>? (Please be specific)

What accommodations are being requested <u>for campus housing</u>? (Please be specific)

BHSU BAPTIST HEALTH SCIENCES UNIVERSITY

EDUCATIONAL INFORMATION

Did you receive accommodations at a previous school(s) for this disability? Yes No

Which school(s)?

What accommodations were provided?

Did you receive accommodations on any standardized test (ACT, SAT, etc.)? Yes No

If yes, which test?

What accommodations were provided?

QUESTIONS ABOUT DISABILITY/ACCOMMODATIONS

Please answer the following questions as thoroughly and honestly as possible in order to assist us in determining what the most appropriate accommodations are for you. *Information provided is **CONFIDENTIAL** to the extent allowed by law.*

1. How does your disability impact you academically, in lab/clinic, and/or in daily activities? Please explain some of the ways in which your disability has manifested itself both currently and historically.

2. How do the requested accommodations help you to compensate for your disability?

3. For the accommodations you are presently requesting, have you ever received these before? If so, where and under what circumstances?

4. Have you ever been denied accommodations? If so, please describe the circumstance.

5. If accommodations have not been used in the past, please address why accommodations are being requested at this time.

I understand that the information provided on this form will be used by the ADA Coordinator at Baptist Health Sciences University to assist in determining the most effective accommodations and/or compensatory strategies for my use.

______________________________________ ______________________________

Student Signature Date

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

At times it may be necessary to consult with a student's health care provider, in most instances this would be the provider that provided the documentation, to assist with accommodation requests. I authorize the provider listed below to release information and/or medical records related to my request for ADA accommodations. I understand that the ADA Coordinator will review this documentation and may contact me for additional information. Furthermore, I grant the ADA Coordinator permission to contact the provider completing this form for additional information as needed.

Name of Provider: ____

Specialty: ____

Clinic/Facility Name: ____

Address: ____

City/State/Zip: ____

Daytime Phone Number: ________________________________

___ **I have read and understand the above information.**

____
Student Name (Please Print)

_____________________________________ ____________________________
Student Signature or Legal Representative Date

_____________________________________ ____________________________
Printed Name of Legal Representative Relationship to Student