Return form to:
Wesleyan College: Disability Resources C/O Jill Amos
4760 Forsyth Road, Macon, GA 31210
Phone (478) 757-5219 Fax (478) 757-2430

REQUEST FOR **DISABILITY SERVICES**

PERSONAL INFORMATION

First Name *Middle Initial* *Last* *Preferred Name*

Street Address *City* *State* *Zip*

Telephone *Campus Box #* *Cell (If applicable)*

ACADEMIC INFORMATION

Year: ❒ First Year ❒ Sophomore ❒ Junior ❒ Senior+ ❒ Other ___________

Major ______________________________________ Minor ______________________________________

First Semester enrolled at Wesleyan ____

TRANSFER STUDENT

Previous College(s) Attended ____

Any individual who feels that she has been denied appropriate accommodations, access, or been discriminated against on the basis of a disability, should file a complaint using the College's Student Complaint Process which can be found in the *Wesleyanne: Student Handbook*.

DOCUMENTATION

Current documentation must be provided by a licensed professional who has relevant training and experience diagnosing and treating the reported condition and is unrelated to the individual being evaluated. All documentation* needs to be on letterhead, typed, dated, and signed. The documentation should be submitted as soon as possible prior to when accommodations are required. Accommodations will not be granted retro-actively. Documentation should include the following information:

1. Name of the student
2. The credentials of the evaluator
3. Date last evaluated
4. A description of the methodology used and test scores that support the diagnosis (if applicable)
5. A clear diagnostic statement
6. Information on the current functional limitations and prognosis of the condition
7. Specific recommended accommodations that are directly related to current functional limitations and explanation of why these accommodations are needed

**Students may elect to use the Wesleyan College Disability Services Verification Form to provide documentation from a licensed professional.*

Upon leaving the College, it is your responsibility to request your documentation be returned to you. All documentation will be destroyed five (5) years after last date of enrollment.

First for Women
WESLEYAN

REQUEST FOR DISABILITY SERVICES

4760 Forsyth Road Macon, GA 31210 (800) 447-6610

AUTHORIZATION FOR **RELEASE OF MEDICAL INFORMATION**

I, ____,DOB ______________, SS# ______________________________

______ (initial) request and authorize the following professionals to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of postsecondary planning and disability accommodation implementation to the Coordinator of Disability Resources;

_____ (initial) also request and authorize the Coordinator of Disability Resources to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of postsecondary planning and disability accommodation implementation to the professional/s listed below; and/or

_____ (initial) also authorize the professional/s listed below to speak with the Coordinator of Disability Resources about my medical, psychological, educational, and/or vocational history, treatment, diagnosis, opinions, and other related information regarding my disability for the purpose of postsecondary planning and disability accommodation.

________________________________	________________________________
Licensed Professional	*Licensed Professional*
________________________________	________________________________
Address	*Address*
________________________________	________________________________
City, State, Zip Code	*City, State, Zip Code*
________________________________	________________________________
Phone/Fax	*Phone/Fax*

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Coordinator of Disability Resources. The revocation will not apply to action taken prior to that date.

Student Signature ____ *Date* ________________

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DISABILITY INFORMATION

Check all that apply:

- ❒ Attention Deficit (Hyperactivity) Disorder (ADD/ADHD)
- ❒ Acquired Brain injury
- ❒ Chronic Health Condition
- ❒ Deaf/ Hard of Hearing
- ❒ Learning Disability
- ❒ Mobility Impairment
- ❒ Neurological Condition Psychological Condition
- ❒ Visual Impairment
- ❒ Autism Spectrum Disorder
- ❒ Other (please identify) ____________________

Please describe your disability, including date and specific name of onset diagnosis.

____

Current Medications: ____________________

Are you registered with the Department of Labor - Vocational Rehabilitation Services? ❒ Yes ❒ No

ACCOMMODATIONS

List the accommodations you are requesting at Wesleyan College:

____

____

** To continue to be considered for academic accommodations, a student must request services each semester. Other accommodation requests must be made annually.*

AUTHORIZATION FOR RELEASE OF INFORMATION TO PARENT/GUARDIAN (OPTIONAL)

Parent/Guardians Name(s) ____________________

Address ____________________ Phone # ____________________

I understand that by signing this form, I authorize representatives of the Academic Center to discuss or release to the above parent/guardian information regarding my disability to assist in the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Disability and Advocacy Resources. This revocation will not apply to action taken prior to that date.

Student Signature ____________________ Date ____________________