Request for Disability Services

Return form to: Wesleyan College – Disability Resources C/O Christy Henry
4760 Forsyth Road * Macon * GA 31210 - Phone (478)757-5219 * Fax (478)757-2430

Personal Information

Name
First Middle Initial Last Preferred Name

Address
Street
City State Zip

Telephone
Cell (If applicable)

Campus Box #

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.
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.

Authorization for Release of Medical Information
(optional)

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 #                                 Phone#
Fax#                                    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 __________________________
Check all that apply:

- Attention Deficit (Hyperactivity) Disorder (ADD/ADHD)
- Mobility Impairment
- Acquired Brain injury
- Neurological Condition
- Chronic Health Condition
- Psychological Condition
- Deaf/ Hard of Hearing
- Visual Impairment
- Learning Disability
- 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 Coordinator of Disability Resources. This revocation will not apply to action taken prior to that date.

Student Signature_________________________________________ Date _________________________________