



First for Women

WESLEYAN

REQUEST FOR DISABILITY SERVICES
4760 Forsyth Road Macon, GA 31210 (478) 757-5219

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.



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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 _____