

Florida Institute of Technology
Counseling & Psychological Services

DISABILITY SERVICES REQUEST FORM – (STUDENT)

Date _____

General Information

Student Number _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone (H)(____) _____ (C)(____) _____

E-mail _____

Major _____

Current Class Standing (please circle one)

Freshman Sophomore Junior Senior Graduate Transfer

Disability Information

What is your diagnosed disability? (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Deaf/Hard of Hearing | <input type="checkbox"/> Blind/Visually Impaired |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Health Impairment | <input type="checkbox"/> Mobility Impaired |
| <input type="checkbox"/> Speech Impairment | <input type="checkbox"/> Psychological Impairment |
| <input type="checkbox"/> Other (Please specify) | |

Describe your disability and how it affects your performance as a student:

Do you have current documentation of your disability? YES NO

If so, you are required to submit your most recent psychological evaluation, complete with all test results and a diagnosis, along with this completed form.

List any medications and dosages you are currently taking, as well as any side effects:

What academic accommodations have you had **in the past**?

What academic accommodations are you **currently** requesting?

Agency Information

Are you currently receiving assistance from any outside agency (i.e. Division of Blind Services, Department of Vocational Rehabilitation) for academic, career, personal counseling or support? YES NO

Agency Name _____ Phone _____ Fax _____

City or County _____ Counselor's Name _____

****Consent of Requesting Party****

I have read the documentation requirements supplied by Counseling & Psychological Services, and I understand and agree to supply the requested documentation in order to verify my disability and receive services. The information contained in this form is true and accurate to the best of my knowledge.

Student's Signature

Date

Also, I understand that disability services are coordinated through two departments, Counseling & Psychological Services and the Academic Support Center.

Counseling & Psychological Services reviews the documentation provided and determines eligibility of academic accommodations that are currently being requested.

Academic Support Center coordinates and implements the academic accommodations, as well as resolves any issues you may have with the academic accommodations.

Therefore, I understand and grant permission for **Counseling & Psychological Services to share information to/and receive information from the Academic Support Center** regarding my disability needs.

Student's Signature

Date

In addition, I understand that I am required to schedule an appointment with **Counseling & Psychological Services** at the **beginning of EVERY academic year** (Fall semester) to discuss my current disability needs and to be reassessed for academic accommodations. I understand that I am also required to schedule an appointment with the **Academic Support Center** at the **beginning of EVERY semester** that I am requesting academic accommodations (Fall, Spring, and Summer semesters), so that I can authorize what professors/instructors should be notified of my accommodations. Further, if at any point I feel my accommodations are not effective, I am responsible for bringing this to Counseling & Psychological Services or the Academic Support Center, so that my academic accommodation plan can be reviewed.

Student's Signature

Date