

Date _____

DOE _____

APPLICATION FOR DISABILITY SERVICES

Name _____ Student ID _____

Address _____
 First Last Middle Initial City ST Zip Code _____

Phone No. (H) (____) _____ (W) (____) _____ E-Mail _____

Live on Campus? Yes _____ No _____ N/A _____

Date of Birth _____ Male ___ Female ___ Emergency Contact _____

Student _____ Major _____ Employee _____ Dept. _____

Classification: Freshman ___ Sophomore ___ Junior ___ Senior ___ Graduate ___ N/A ___

Explain your disability and current treatment: _____

What accommodations are you requesting? _____

Do you take prescription medication? Please name it, the dosage and the physician who prescribed it.

Services or any other agency? If you answered yes, please name your counselor or contact person and his/her location. _____.

Once you make application for services and provide the appropriate documentation, the Disability Services Coordinator/Director of Human Resources will review your documentation and inform you of your status as a student or employee with a disability.

Permission to Release Information

I _____, hereby give my permission to Troy University to

Print Name

discuss information concerning my disability and accommodations and/or to release documentation on my disability, with individuals who will be involved in the delivery of services to me for my benefit. I also give permission for other agencies and individuals to discuss and release information to the Troy University Disability Services Coordinator. In addition, pertinent