

# Office of Disability and Access Services Registration

Application date: \_\_\_\_\_

## PERSONAL INFORMATION

Full name: \_\_\_\_\_ Legal name (if different): \_\_\_\_\_

Student ID number: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Gender identity: \_\_\_\_\_ Preferred pronouns: \_\_\_\_\_

Mailing address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Email address: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you a veteran or active military member? ☐ Yes ☐ No

Briefly describe why you are contacting the Office of AccessAbility Services (OAS): \_\_\_\_\_

## HOW WERE YOU REFERRED TO OAS? CHECK ALL THAT APPLY

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Advising offices    | <input type="checkbox"/> Family         | <input type="checkbox"/> Self                    |
| <input type="checkbox"/> Career Services     | <input type="checkbox"/> Friend         | <input type="checkbox"/> Student Health Services |
| <input type="checkbox"/> Counseling Services | <input type="checkbox"/> Medical doctor | <input type="checkbox"/> Other _____             |
| <input type="checkbox"/> Dean of Students    | <input type="checkbox"/> Professor      |  |

## DISABILITY CATEGORY CHECK ALL THAT APPLY

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Learning disability                                 | <input type="checkbox"/> Neurological condition                  |
| <input type="checkbox"/> Allergy                  | <input type="checkbox"/> Mobility impairment<br>(temporary or permanent)     | <input type="checkbox"/> Psychiatric/Mental health<br>impairment |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Multiple chemical sensitivity                       | <input type="checkbox"/> Seizure disorder                        |
| <input type="checkbox"/> Blindness/Low vision     | <input type="checkbox"/> Neurocognitive disorders (TBI/<br>Concussion, etc.) | <input type="checkbox"/> Speech/Language impairment              |
| <input type="checkbox"/> Chronic health condition |  | <input type="checkbox"/> Unsure                                  |
| <input type="checkbox"/> Deaf/Hard of hearing     |  |  |

Formal diagnosis/es: \_\_\_\_\_



Please describe your disability and how it currently impacts major life activities (Eating, Walking, Seeing, Hearing, Speaking, Breathing, Working, Performing Manual Tasks, Learning, Standing, Sleeping, Reading, Concentrating, Thinking, Communicating etc.)

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Have you ever received accommodations before? ☐ Yes ☐ No

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If yes, please describe:

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Do you or have you used any adaptive technology or devices? If so, please describe what has been the most helpful:

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Please list the accommodations that you feel are necessary to allow you to access our curriculum and community and how each relates to your experience of your disability.

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## **DOCUMENTATION REQUIREMENTS**

In determining reasonable accommodations, we consider each student's experience, history, request and the characteristics of each Goodwin course and program. Students are a vital source of information. In many cases, to guide the process and to help determine reasonable and appropriate accommodations, we may request information from other sources in order to establish the connection between the disability and the barrier.

View [documentation guidelines](#) or contact ODAS.



## CERTIFICATION AND AUTHORIZATION

Under the Family Educational Rights and Privacy Act (FERPA), ODAS may share information and communicate with appropriate University personnel on a need-to-know basis in order to facilitate the process of determining accommodation eligibility and/or implementation. In limited circumstances, specific information may be required to be disclosed in order to protect individuals in an emergency or to comply with law and/or University policies and procedures.

- ☐ I give permission for the Office of Disability and Access Services to speak with or request information from the treating professional providing documentation (if not attached) to support my accommodation request(s) if needed to make a decision.

I understand that this authorization is voluntary: ☐ Yes ☐ No

If yes: This authorization will expire 180 days from the date on which I sign below. I understand that I may revoke this authorization at any time by providing written notice to ODAS.

## NAME OF PROFESSIONAL(S) AND CONTACT INFORMATION:

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## DISCLOSURE INFORMATION

- ☐ I certify that the information entered on this form is accurate. I understand that my accommodation request(s) cannot be considered until appropriate documentation is submitted. I understand that disclosing a disability at this time does not necessarily confirm eligibility for services or accommodations. I understand that the Office of Disability and Access Services will make every attempt to quickly review all requests for accommodations, the verification process may take several weeks or longer, depending upon the complexity of the request.
- ☐ I understand Goodwin's use of the information on this form as stated above. If I responded affirmatively above, I am giving permission for my treating professional to be contacted, if necessary, to determine accommodation eligibility.

Student signature: \_\_\_\_\_

Date: \_\_\_\_\_

ODAS Manager signature: \_\_\_\_\_

Date: \_\_\_\_\_