Date _____

DOE_____

APPLICATION FOR DISABILITY SERVICES

Name_____Student ID_____
First Last Middle Initial

Address_____ 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