



# MOUNT MARTY UNIVERSITY

LEARNING ACCESSIBILITY SERVICES

## Application for Accommodations

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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Year: Fr. \_\_\_\_ So. \_\_\_\_ Jr. \_\_\_\_ Sr. \_\_\_\_

Campus Address (if applicable): \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Major: \_\_\_\_\_ Advisor: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

### Type of disability (Check all for which you are submitting documentation):

- Autism Spectrum Disorder
- Attention Deficit Hyperactive Disorder (ADHD)
- Blind/Vision Impairment
- Deaf/Hard of Hearing
- Learning Disability (please specify) \_\_\_\_\_
- Mobility/Physical
- Speech/Language Impairment
- Health Impairment (please specify) \_\_\_\_\_
- Psychological/Psychiatric Disorder (please specify) \_\_\_\_\_
- Traumatic Brain Injury (TBI)
- Other (please specify) \_\_\_\_\_

**Nature of disability** (Please explain how the disability interferes with activities in your life, such as your courses, your program of study, residential life, and other college activities):

What **types of accommodations** have you *previously* used and where? (list high school and/or previous college):

**Accommodations requested at MMU** (\*Documentation should support requests for accommodations or services)

Have you received the **Disability Services Documentation Criteria** from Mount Marty University? \_\_\_ Yes \_\_\_ No

Are you currently a client of Vocational Rehabilitation Services? \_\_\_ Yes \_\_\_ No

Name of Case Manager: \_\_\_\_\_ City/State \_\_\_\_\_

If not, would you like information about the agency? \_\_\_ Yes \_\_\_ No

I certify that the information provided on this form is accurate to the best of my knowledge. I understand that I must provide disability documentation to support the need for requested accommodations. I understand that reasonable accommodations are determined after a thorough review of the current documentation and a visit with the Director of Disability Services. Finally, I understand that communicating my disability accommodation needs to my instructors is my responsibility, and no accommodations will be granted without the proper forms signed by an instructor from each course **& returned to the Learning Accessibility Services Office.**

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

Please bring the **Disability Services Documentation Criteria** form to your health professional to ensure we receive comprehensive documentation for our files and in preparation for potential national standardized tests that require sufficient paperwork to grant accommodations.  
.....

*To be filled out by the Learning Accessibility Services (LAS) Office after documentation is submitted*

Health Professional Providing Necessary Documentation Information

Name: \_\_\_\_\_

Organization: \_\_\_\_\_

Phone #: \_\_\_\_\_

Sent to MMU on (date): \_\_\_\_\_

**Final Determination of Accommodations**

Mount Marty University Learning Accessibility Services:

\_\_\_ Approves \_\_\_ Provisionally Approves \_\_\_ Does Not Approve

The following accommodations:

LAS Signature: \_\_\_\_\_ Date: \_\_\_\_\_