MOUNT MARTY
UNIVERSITY
DISABILITY SERVICES

Application for Accommodations

Please Print

Name: _____ Date: _____

Date of Birth:_____ Grad Program: _____

Campus:_____

Permanent Address:_____

Phone Number:_____ Email Address: _____

Major: _____

Advisor:_____

Emergency Contact Name & Phone #: _____

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

___Autism Spectrum Disorder
___Attention Deficit Disorder/ADHD
___Blind/Vision Impairment
___Deaf/Hard of Hearing
___Learning Disability (please specify)_____
___Mobility/Physical
___Speech/Language Disorder
___Health Impairment (please specify)_____
___Psychological/Psychiatric Disorder (please specify)_____
___Traumatic Brain Injury (TBI)
___Other _____

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 MMC (documentation should support requests for accommodations or services)

_____
_____
_____
_____

Have you received the **Disability Services Documentation Criteria** from Mount Marty College? ____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 will need to 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 Disability Services Coordinator. 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 Director of Disability Services**.

Signature:_____ Date: _____

Please bring the **Disability 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 in order to grant disability accommodations.

To be filled out by Disability Services Coordinator after documentation is submitted.

What health professional has provided the necessary documentation?
Name: _____
Organization:_____
Phone #: _____
Sent to MMC on (date) _____

Final Determination of Disability Accommodations

Mount Marty College Office of Disability Services:
_____ Approves _____ Provisionally Approves ____ Does Not Approve

The following disability accommodations:
_____
_____
_____
_____

Director Signature: _____ Date: _____