

HAWKEYE COMMUNITY COLLEGE STUDENT REASONABLE ACCOMMODATION REQUEST AND RELEASE FORM

NAME: _____ SSN: _____ BIRTHDATE: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 PHONE: _____ EMAIL: _____
 MAJOR: _____ STARTING DATE: _____

THIS FORM SHOULD BE COMPLETED WHEN A STUDENT HAS INDICATED HIS OR HER DESIRE TO REQUEST A REASONABLE ACCOMMODATION FROM THE COLLEGE. UPON COMPLETION, THIS FORM MUST BE DELIVERED TO THE SPECIAL NEEDS COORDINATOR AND KEPT SEPARATE FROM THE STUDENT'S GENERAL ENROLLMENT FILE.

PLANNING AHEAD IS ESSENTIAL TO ENSURE THAT ACCOMMODATIONS CAN BE MET IN A TIMELY MANNER.

TO BE COMPLETED BY THE STUDENT. IT IS THE RESPONSIBILITY OF THE STUDENT TO PROVIDE DIAGNOSTIC DOCUMENTATION OF A DISABILITY. THIS APPLICATION IS INACTIVE UNTIL DOCUMENTATION HAS BEEN RECEIVED.

- IDENTIFY AND DESCRIBE THE PHYSICAL OR MENTAL DISABILITY, ILLNESS, CONDITION, OR DISEASE WHICH IS THE BASIS FOR YOUR REQUEST FOR REASONABLE ACCOMMODATION(S) BY THE COLLEGE AND IDENTIFY HOW IT HAS AFFECTED YOU:

- CHECK THE ACCOMMODATION(S) YOU ARE REQUESTING.

Testing Accommodations:

- Extended Time
- Use of a Calculator
- Quiet Setting for Testing
- Separate Setting for Testing
- Tests Read
- Scribe for short answer/essay questions
- Computer for Essay Exams

Classroom/Learning Accommodations:

- Note Taking Assistance
- Interpreters (Sign Language)
- Preferential Seating
- Copy of Power Point Notes
- Enlarged Printed Materials Font Size _____
- Option to take short breaks/move around when needed
- Tutors (available in Academic Support Center for classes beyond Success Course Level)
- Adapted textbooks (Documentation must specifically support this option and must be in our office approximately six weeks in advance of the need)
- Record Lectures

Other _____

3. IDENTIFY THE NAMES AND ADDRESSES OF PHYSICIANS, THERAPISTS, PSYCHOLOGISTS, OR OTHER HEALTH CARE PROVIDERS WHO HAVE INFORMATION OR DOCUMENTATION CONCERNING YOUR DISABILITY, ILLNESS, CONDITION, OR DISEASE OR YOUR NEED FOR A REASONABLE ACCOMMODATION BY THE COLLEGE:

VOC REHABILITATION COUNSELOR: _____

Address: _____

Phone Number: _____ Fax: _____

AREA EDUCATION AGENCY: _____

High School: _____

Address: _____

Phone Number: _____ Fax: _____

Special Education/Resource Room Teacher: _____

MEDICAL DOCTOR: _____ Phone: _____ Fax: _____

Address: _____

Are you taking medication that affects your; ability to learn; memory; concentration; attention span or alertness?

Yes No

OTHER: _____

RELEASE OF INFORMATION

I HEREBY AUTHORIZE THE ABOVE-LISTED HEALTH CARE PROVIDERS AND ANY OTHERS WHO HAVE TREATED ME TO RELEASE TO HAWKEYE COMMUNITY COLLEGE ALL MEDICAL AND PSYCHOLOGICAL RECORDS CONCERNING MY ABILITY TO: 1) BE CONSIDERED FOR ADMISSION TO MY DESIRED PROGRAM, COURSE, OR ACTIVITY; 2) MEET AND PERFORM THE ACADEMIC AND TECHNICAL STANDARDS REQUISITE TO PERFORMANCE OF THE EDUCATION PROGRAM OR ACTIVITY THAT IS THE SUBJECT OF THIS REQUEST; OR 3) ENJOY EQUAL BENEFITS AND PRIVILEGES OF EDUCATION AS ARE ENJOYED BY OTHER SIMILARLY SITUATED APPLICANTS OR STUDENTS WITHOUT DISABILITIES.

I CERTIFY THAT THE FOREGOING STATEMENTS ARE COMPLETE, ACCURATE, AND TRUE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THE COLLEGE MAY REQUEST ME TO UNDERGO TESTING OR EVALUATION BY MEDICAL PERSONNEL FOR THE PURPOSE OF ESTABLISHING THE EXISTENCE AND EXTENT OF MY DISABILITY, ILLNESS, CONDITION, OR DISEASE AND MY NEED FOR A REASONABLE ACCOMMODATION, IF ANY.

SIGNATURE: _____ DATE: _____

COMPLETE AND RETURN TO:

**Student Services
Hawkeye Community College
P.O. Box 8015
Waterloo, IA 50704-8015
1-800-670-4769
1-319-296-4014**