BLUEFIELD COLLEGE
Academic Center for Excellence

Academic Support Services
Accommodations and Accessibility - Active Student Form

Last name _____ First name _____ M.I. _____

Street Address _____

City _____ State _____ Zip _____

Cell phone _____ E-mail address _____

Student I.D. # _____ Sex ___ Marital status _____ Veteran? ___

Current class: o Freshman o Sophomore o Junior o Senior
o Entering freshman o currently enrolled o Transfer o Inspire Online Student o Transient

Major _____ Academic advisor _____

Rehabilitation Services client? _____ Rehab Counselor _____

Office _____ Phone _____

Please list courses/class schedule for the semester in which accommodations are being sought:

Course	Instructor	Day & Time
(ex. 1013 Introduction to Writing	*Dr. Wayne Massey*	*MWF 11 a.m.)*

Disability

o Visual impairment o Hearing impairment oManual/Mobility impairment
o Medical impairment o Psychological impairment o Learning Disorder
o Attention deficit disorder o Traumatic brain injury o Other health impaired (please explain below:)

_____

_____

Confidential Information Release Form

I understand that the Academic Support Services office is committed to helping me identify and arrange appropriate accommodations, and develop strategies for success in my educational endeavors. I also understand that for the Academic Support Services office to be of assistance to me, it is important that I actively participate in the programs and services offered. Therefore, I agree to communicate regularly with the Academic Support Services staff. I understand that any information will be treated as confidential and will be used to prove the necessary accommodations, to evaluate my academic progress, and to determine the effectiveness of services provided.

I, _____, authorize the Academic Support Services office staff to have access to any and all academic records as needed to assist me in planning schedules and evaluating academic progress.

I, _____, give permission for the Academic Support Services staff to divulge whatever information they deem necessary to other professional members of the University concerning academic, advising, counseling, testing, and/or other relevant matters.

I, _____, give permission for the Academic Support Services staff to contact those external service providers (medical doctors, psychologists, etc.) who have provided information concerning my disability, in order to obtain information needed to determine appropriate and effective accommodations and services.

I, _____, give permission for the Academic Support Services staff to communicate with the following persons concerning any academic, personal, medical or psychological issues arising during my time at Bluefield College.

Name _____ relationship _____

Name _____ relationship _____

Name _____ relationship _____

Name _____ relationship _____

_____ _____

Student signature Date

Form adapted from Kennesaw State University, Disabled Student Support Services, Kennesaw, Georgia.