UIN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI \_\_\_\_

 Male Female Other Identity \_\_\_\_\_\_\_\_\_\_\_

 (*Please Specify)*

 Date of Birth

**Permanent Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permanent Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Country of Citizenship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Campus Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Campus/Cell Phone (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian

Undergraduate Graduate

 Are you a veteran of US military service? Yes No

**RACE/ETHNICITY (optional for statistical purposes)**

Are you Hispanic or Latino? Yes No

**Select one or more races:**

\_\_\_\_\_American Indian/Alaska Native Asian Black/African American

\_\_\_\_\_Native Hawaiian or Other Pacific Islander White

**ACADEMIC HISTORY**

|  |  |  |
| --- | --- | --- |
| **High Schools Attended** | **Dates of Attendance****From**  **To** | **Disability-Related Accommodations / Services** |
|  |  |  |
|  |  |  |

**Did you have an IEP?** \_\_\_\_ **Yes \_\_\_\_ No Did you have a 504 plan? \_\_\_\_ Yes \_**\_\_\_ **No**

|  |  |  |
| --- | --- | --- |
| **Colleges / Universities Attended** | **Dates of Attendance****From** **To** | **Disability-Related Accommodations / Services** |
|  |  |  |
|  |  |  |

Dear Prospective Student: Thank you for your interest in services for students with disabilities offered by the Office of Disability Services (ODS). It is important that you complete and return this application **with** supporting disability documentation as soon as you are admitted to the university or are aware of a disability-related need for services. Such information will help us work with you to plan effective academic adjustments, auxiliary aids, or services during your tenure as a student at Illinois Springfield. Refer to the ODS document entitled *Documentation Requirements* for specific documentation requirements for your disability. **Please note that services cannot begin until a completed application (application and disability documentation) is on file in the ODS Disability Services Office.**

**GENERAL NATURE OF DISABILITY / DISABILITIES**

Please describe your disability, include diagnosis as well as the cause and date of onset. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you receive SSI or SSDI? Yes No

Do you receive support through your state rehabilitation services office? Yes No

If yes, please provide counselor information below

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

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DISABILITY-SPECIFIC INFORMATION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please list current medications:

Are there any side effects with these medications? If yes, please explain. Yes No

**USE OF ASSISTIVE TECHNOLOGY, DOCUMENT CONVERSION, OR CAPTIONING**

Check all that apply:

Screen Reader \_\_\_\_\_\_\_\_ Speech Recognition \_\_\_\_\_\_\_\_ Keyboard Adaptations \_\_\_\_\_\_\_\_

MP3’s \_\_\_\_\_\_\_\_ e-text\_\_\_\_\_\_\_\_ Large Print \_\_\_\_\_\_\_\_ Captioning\_\_\_\_\_\_\_\_

Please list programs and describe use: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **TO BE COMPLETED ONLY BY INDIVIDUALS WITH PRIMARY OR SECONDARY VISION DISABILITIES**

Travel Aides: Cane \_\_\_\_\_\_\_\_\_\_\_ Dog Guide \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Mobility Training: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you travel independently? Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_

**TO BE COMPLETED ONLY BY INDIVIDUALS WITH PRIMARY OR SECONDARY HEARING DISABILITIES**

Do you wear hearing aids? No \_\_\_\_\_ Yes \_\_\_\_\_\_\_ If Yes, One ear\_\_\_\_\_\_ Bilateral\_\_\_\_\_\_

Primary means of expressive and receptive communication:

Speech Reading \_\_\_\_\_\_\_\_ FM System \_\_\_\_\_\_\_\_ Sign Language \_\_\_\_\_\_\_\_

If so, what type? ASL \_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED ONLY BY INDIVIDUALS WITH DISABILITIES AFFECTING MOBILITY**

Do you use any mobility aids? Prosthesis (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Braces \_\_\_ Crutches \_\_\_\_ Cane \_\_\_\_ Manual Wheelchair \_\_\_\_ Motorized wheelchair/cart \_\_\_\_

Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_ Do you require personal assistant (PA) help? Yes\_\_\_\_ No\_\_\_\_

**UNIVERSITY OF ILLINOIS SPRINGFIELD ENROLLMENT**

College\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Major\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Year in School: Freshman\_\_\_\_ Sophomore\_\_\_\_ Junior\_\_\_\_ Senior\_\_\_\_ Graduate\_\_\_\_

Entrance date: Summer Session \_\_\_\_\_ Fall \_\_\_\_ Spring \_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you an Online Degree seeking student? Yes No

Are you enrolled in any online courses this semester? Yes No

 **STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION**

I, the undersigned, understand that in order for the Office of Disability Services (ODS) to verify my disability, as well as the functional manifestations of my disability for which academic adjustments, auxiliary aids and/or other accommodative services may be required, ODS must obtain pertinent student evaluations, psychological reports, transcripts, and medical reports. I understand that to obtain these reports, this form must be signed and on file in the Office of Disability Services (ODS).

I understand that no one other than ODS personnel has immediate access to my ODS files, and that any information regarding my disability which is gained from these files shall be considered **confidential** and will only be shared with others within the institution on a need-to-know basis. I further understand that my reports will not be released by ODS except in accordance with federal and state laws.

Therefore, for the purposes noted above and in accordance with the conditions specified, I hereby authorize release of information from reports to authorized personnel at the University of Illinois Springfield and the Office of Disability Services. I understand that I may revoke this consent at any time.

***SIGNED***  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***DATE*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***PARENT/GUARDIAN(IF STUDENT IS UNDER 18 YRS. OF AGE)*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL PROFESSIONAL/AGENCY AUTHORIZATION FOR RELEASE OF INFORMATION**

I, authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_to release

*(Person or Agency)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(State specific nature of information to be disclosed)*

Concerning\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Receiving Agency or Individual)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Receiver’s Address)*

for the purpose of\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Further evaluation, continuing treatment, etc.)*

This consent is valid until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this at any time and that the above-mentioned individual or agency authorized to receive this information has the right to inspect and copy the information to be disclosed. It has been explained to me that if I refuse to consent to this release of information, the following are consequences (specify, if any):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**WITNESS:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***SIGNATURE:\_\_\_\_\_\_\_\_\_\_***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***DATE:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***UIN:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ***DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\* If signature is not of recipient, indicate legal relationship of signatory to recipient and legal basis on which consent is given for recipient.