ALCORN STATE UNIVERSITY

Department of Health & Disability Services
Rowan Hall Health Services Center ● 1000 ASU Drive, 779 ● Lorman, MS 39096
Office: 601-877-6460 ● Fax: 601-877-2340

REQUEST FOR DISABILTIY ACCOMMODATIONS APPLICATION

(PLEASE PRINT)

A New Application & Class Schedule Must Be Submitted Each Semester

DATE: ____________________________

Type of Accommodations:
□ Academic □ Housing

□ New Applicant □ Renewal Applicant
Term of request (check only one)
□ Fall __________ □ Spring___________

□ Summer I _______ □ Summer II ______

NAME: ____

ASU I.D: __________________________________ CLASSIFICATION: __________________

E-MAIL ADDRESS: ____

COMPLETE HOME ADDRESS: ____

CITY: _________________________ STATE: ___________ ZIP CODE: __________

HOME TELEPHONE: _____________________________ CELL: ______________________

COMPLETE LOCAL ADDRESS: ____

CITY: ____________________________ STATE: __________ ZIP CODE: ___________

LOCAL TELEPHONE #: ____

GENDER: _______________ DATE OF BIRTH: ________________________

CHECK ALL THAT APPLY:

□ Attention Deficit Disorder **□ Attention Deficit Hyperactive Disorder**

□ Chronic Illness **□ Hearing Impairment**

□ Learning Disability **□ Orthopedic Impairment**

□ Psychological **□ Traumatic Brain Injury**

□ Visual Impairment **□ Other _________________________________**

FUNCTIONAL LIMITATIONS:

(Please select the extent to which you believe your diagnosed condition affects the following major life activities)

ACTIVITY	NONE	UNDETERMINED	MILD	SUBSTANTIAL
Caring for oneself				
Talking				
Hearing				
Breathing				
Seeing				
Walking/Standing				
Lifting/Carrying				
Sitting				
Performing Manual Tasks				
Eating				
Working				
Learning				
Reading				
Writing/Spelling				
Calculating				
Memorizing				
Concentrating				
Listening				

Describe the limitations of your disability.

____

____

____

____

Describe the accommodations you are requesting.

____

____

____

____

IN ORDER TO RECEIVE ACADEMIC AND RESIDENTIAL ACCOMMODATIONS THROUGH ALCORN STATE UNIVERSITY YOU MUST PROVIDE THE OFFICE OF DISABILITY SERVICES DOCUMENTATION THAT SPECIFIES YOUR DISABILITY.

STUDENTS ARE ENCOURAGED TO UPDATE THEIR REQUEST FOR ACADEMIC AND RESIDENTIAL ACCOMMODATIONS PRIOR TO EACH SEMESTER TO AVOID A DELAY IN RECEIVING SERVICES.

_______________________________ _______________________________

SIGNATURE **DATE**

***Attach copy of class schedule**

***Remember to update request for accommodations each semester**

AUTHORIZATION, CONSENT & RELEASE

Alcorn State University
Rowan Hall Health Services Center
1000 ASU Drive, 779
Alcorn State, MS 39096
Office: 601-877-6460
Fax: 601-877-2340

Authorization must be signed by the patient, or by the nearest relative in the case of a minor, or when patient is physically or mentally incompetent.

ASU ID #: _________________ Date: _____________________

Patient's Name: _________________________________ Date of Birth: ______________________

Name of Provider/Facility: ____

Name & Address of Provider/Facility: ____

City: ______________________________ State: __________________ Zip Code: ________________

Office#: _____________________________________ Fax#: __________________________________

AUTHORIZATION FOR RELEASE OF INFORMATION

I, the above-name patient at the above-named facility, hereby authorize the said facility to furnish such professional information, in accordance with the policy of the facility, as may be necessary for the completion of my patient care insurance claims by the above-named third party (health insurance carrier) from the medical records compiled during my present patient stay and hereby release the said facility from all legal liability that may arise from the release of the information requested.

Patient Signature_____________________________________ Date_______________________

Staff Signature_______________________________________ Date_______________________

*I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

*I understand that this authorization is valid for 1 year, unless revoked by my written notice, provided said notice is received prior to release of the above designated information.

*I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment.

*I understand that any disclosure of information carries with it the potential of an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about this disclosure of my health information, I may contact the Director of Health & Disability Services at 601-877-6460.

Alcorn State University
Department of Health & Disability Services
Phone# 601-877-6460
Fax# 601-877-2340

EMERGENCY EVACUATION CHECKLIST

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To be used for practice, drills, and actual emergencies

Today's Date ________________________________ ASU ID# ________________________________

Student Name ____

□ Off- Campus

□ On-Campus

Dorm Location ______________________________ Room # ________________________________

Room phone # ______________________________ Cell phone # ____________________________

List type of assistance needed. (mobility, visual, hearing, cognitive/emotional/social)

____
____
____
____

Please provide a copy of your class schedule

Tape Recorded Lecture Procedure Form

Under Section 504 Postsecondary Education of the 1973 Rehabilitation Act and the Americans with Disabilities Act, institutions of higher education must provide reasonable accommodations to a student's known disability and may not deny equal access to the institution's programs, courses, and activities. Tape recording lectures is a reasonable accommodation. Students with documented disabilities have the right to record class lectures with either a tape recorder or digital recording device.

1. This is provided as an accommodation for the student's personal study only.
2. Lectures recorded for this purpose may not be shared with other people without the consent of the lecturer.
3. Recorded lectures may not be used in any way against the faculty member, other lecturers, or students whose classroom comments are recorded as a part of the class activity.
4. Information contained in the recorded lecture is protected under federal copyright laws and may not be published or quoted without the written consent of the lecturers and without giving proper identity and credit to the lecturer.
5. Posting videos and/or recordings on YouTube, Facebook, or other social media sites is considering sharing, and is prohibited without the expressed written consent of the lecturer.

I understand the Disability Services Recorded Lecture Procedure stated above, and agree to abide by the procedure while attending Alcorn State University.

______________________________	______________________
Printed Student Name	ASU ID#
______________________________	______________________
Student Signature	Date
______________________________	______________________
Disability Services Staff Signature	Date

STUDENT CONSENT TO RELEASE INFORMATION TO PARENT (S), GUARDIAN, SPOUSE, OR OTHERS

(Please Print)

Student's Name: ____

Date of Birth: ____________________ ASU ID#: ____________________

Home Address: ____

City: __________________ State: ____________ Zip Code: ____________

Home Telephone#: __________________ Cell Phone#: __________________

Campus/Local Address: ____

City: __________________ State: ____________ Zip Code: ____________

By signing below, I authorize the Alcorn State University Rowan Hall Health Services Center to release or discuss information regarding my Health Records.

We will not release a student's health records to anyone without a signed consent from the student.

Name of parent (s), guardian, spouse, or others that you wish to grant permission to:

Name: ______________________ *Last 4 digits of Social Security Number: ______

Name: ______________________ *Last 4 digits of Social Security Number: ______

Name: ______________________ *Last 4 digits of Social Security Number: ______

Name: ______________________ *Last 4 digits of Social Security Number: ______

***This information will only be used for identification purposes.**

This authorization will remain in effect until revoked in writing.

Student Signature: ____________________________ Date: ______________

Staff Signature: ____________________________ Date: ______________

Alcorn State University

Department of Health & Disability Services

RELEASE OF INFORMATION

Date: ______________________________

I, _________________________________ hereby give the Department of Health & Disability Services at Alcorn State University permission to obtain information that qualifies me for services from this program. Information that can be given to the Department of Health & Disability Services includes but no limited to: Financial Aid Records, Residential Reports, Grade Reports, Academic Performance, Medical, Psychological, Vocational and/or Education Reports. I understand that this information will only be used to assist me in my academic endeavors at Alcorn State University, and will remain confidential. I may choose to revoke this release at any time. I have been informed of my rights about confidentiality.

Last 4-digit of Social Security number: ___________________________________

Date of Birth: ____

ASU ID#: ____

Student Signature: ____

Staff Signature: ____

How Are We Doing? Term ___________ ADA Student Survey

The Alcorn State University Department of Health & Disability ADA staff welcomes your feedback and your answers will be kept confidential. Thank you for your participation.

Are you aware and understand your role and responsibilities for requesting accommodations?

○ No ○ Somewhat ○ Mostly ○ Yes

Did you receive reasonable accommodations as requested?

○ No ○ Somewhat ○ Mostly ○ Yes

Did you receive accommodations in a helpful time frame?

○ No ○ Somewhat ○ Mostly ○ Yes

Has ASU's staff been cooperative in response to providing your accommodation?

○ No ○ Somewhat ○ Mostly ○ Yes

Were you satisfied with your accommodation plan?

○ No ○ Somewhat ○ Mostly ○ Yes

Has disability services helped you have a more equal educational opportunity as student's without disabilities?

○ No ○ Somewhat ○ Mostly ○ Yes

Would you refer a student with a disability to the ADA office?

○ No ○ Somewhat ○ Mostly ○ Yes

How knowledgeable was the staff with providing services to meet your academic accommodation plan?

○ No ○ Somewhat ○ Mostly ○ Yes

Do you feel ASU is a disability-friendly campus?

○ No ○ Somewhat ○ Mostly ○ Yes

Please provide any suggestions or comments:

____

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NOTES: