

Date \_\_\_\_\_

DOE \_\_\_\_\_

### APPLICATION FOR DISABILITY SERVICES

Name \_\_\_\_\_ Student ID \_\_\_\_\_

                    First                    Last                    Middle Initial  
Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone No. (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Live on Campus? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Emergency Contact \_\_\_\_\_

Student \_\_\_\_\_ Major \_\_\_\_\_ Employee \_\_\_\_\_ Dept. \_\_\_\_\_

Classification: Freshman \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior \_\_\_ Graduate \_\_\_ N/A \_\_\_

Explain your disability and current treatment: \_\_\_\_\_

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

What accommodations are you requesting? \_\_\_\_\_

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

Do you take prescription medication? Please name it, the dosage and the physician who prescribed it.

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

Do you receive assistance from Vocational Rehabilitation, Veteran's Affairs, Student Support Services or any other agency? If you answered yes, please name your counselor or contact person and his/her location. \_\_\_\_\_.

Once you make application for services and provide the appropriate documentation, the Disability Services Coordinator/Director of Human Resources will review your documentation and inform you of your status as a student or employee with a disability.

## Permission to Release Information

I \_\_\_\_\_, hereby give my permission to Troy University to  
Print Name  
discuss information concerning my disability and accommodations and/or to release documentation on my disability, with individuals who will be involved in the delivery of services to me for my benefit. I also give permission for other agencies and individuals to discuss and release information to the Troy University Disability Services Coordinator. In addition, pertinent information related to my disability may be provided to facilitate the delivery of services on a “need to know” basis. These individuals include, but are not limited to (1) parents, (2) guardian, (3) spouse, (4) faculty and staff of Troy University, and/or (5) other professionals or agencies involved in services, support, accommodations or consultation as deemed appropriate by the Disability Services Coordinator/Director of Human Resources.

For students, permission to release information will remain in effect until graduation. For employees, permission remains in effect throughout the term of employment with Troy University. Permission may be rescinded in writing at any time.

\_\_\_\_\_  
Signature of Student/Employee

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Disability Services Coordinator/  
Director of Human Resources

\_\_\_\_\_  
Date Signed

**Notice to Party Receiving Information:** This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.