APPLICATION FOR SERVICES

Disability Support Services
Mayville State University
330 3rd Street NE
Mayville, ND 58257

NAME: _____ ID# _____

PHONE: _____BIRTH DATE: _____

LOCAL ADDRESS: _____

PERMANENT ADDRESS: _____

EMAIL: _____ SCHOOL EMAIL: _____

WHAT IS YOUR DISABILITY: _____

_____

HOW DOES IT AFFECT YOU IN YOUR COURSES? _____

_____

ARE YOU RECEIVING SERVICES FROM:

___Voc. Rehab: Cslr. Name_____ Cslr. # _____

Disability Services for Students agrees to keep information/records concerning the student's disability confidential in compliance with the Family Rights and Privacy Act (FERPA), ND state statutes and the professional and ethical standards of the Association of Higher Education and Disability (AHEAD).

While DSS staff will not release documentation nor reveal specific details of a student's condition to Mayville State University faculty or staff, they will verify that the documentation is on file at DSS and share information about the purpose of the documentation.

I certify that the information provided on this form is correct. I understand that in order to be eligible for specific accommodations I must provide documentation of my disability that supports the need for those accommodations. I also understand that the accommodations and/or disability-related services provided will be determined by DSS.

SIGNATURE: _____DATE: _____

Disability Support Services · Mayville State University
Mayville, ND 58257 Phone: 701-788-4675· Fax: 701-788-4748

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Student (last, first, middle initial) | Student ID # | Birthdate

Street Address | City | State | Zip Code

STUDENT RELEASE AND SIGNATURE

1. I Hereby authorize: (Name and Address of Person/Agency)

Name	Agency	Address
Stephanie Bowlin	Mayville State University	330 3rd St NE, Mayville, ND 58257

To (check one): ☐ release information to ☐ receive information from ☐ exchange information with

_____.

2. The above authorization is restricted to the following designated records and communication (check all that apply):

☐ Psychological ☐ Addiction ☐ Verbal Communication ☐ Other (explain:_____ _____)

☐ Education ☐ Medical ☐ Written Communication

3. The information will be used for: (check all that apply):

☐ Determination of eligibility for services ☐ Provision of services/accommodations

☐ Consultation ☐ Other (explain: _____)

4. This release of information consent remains in effect until _____ (date) or as otherwise indicated here_____.

STUDENT CONSENT:

This authorization is voluntary and remains in effect until the above date or event, unless specifically revoked by written notice to the agency or person. Any information released prior to my written revocation of this authorization shall not be a breach of confidentiality. A photocopy of this release is effective as the original.

Signature of Student | Date

Signature and Position of Academic Support Staff | Date

☐ *CHECK IF APPLICABLE-NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING ADDICTION RECORDS

This information has been disclosed to your from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug use patient.

GUIDELINES FOR DISABILITY DOCUMENTATION

Documentation must indicate how the disability limits the student in a major life activity as outlined in Section 504 of the Rehabilitation Act and The Americans with Disabilities Amendments Act. The information submitted is used to determine reasonable accommodations and/or disability-related services for this student a Mayville State University.

DOCUMENTATION PROVIDED BY THE STUDENT SHOULD INCLUDE THE FOLLOWING:

- A **clear diagnostic statement** that describes how the condition was diagnosed, information on the functional impact and details on the progression of the condition. Dates of the original and current diagnostic evaluations need to be included.
- A **description of the diagnostic methodology**, criteria, evaluation methods, procedures, tests used, dates administered, clinical narrative, observations and specific results that are congruent with the particular disability.
- A **description of the current functional limitations and how these limitations affect the student in a major life activity.** A "functional limitation" is defined as an adverse effect on a major life activity caused by the disability. Functional limitations should be described in terms of how severely the activity is affected by the disability; the frequency with which the activity is affected and how pervasive the disability is in performance of the life activity.
- A **description of current and past accommodations, services and/or medications and their effectiveness** in relation to the functional impact of the disability. Information about any significant side effects from current treatment or medications and its effect on physical, perceptual, behavioral and cognitive performance is helpful.
- A **description of the expected progression or stability of the disability** including the expected changes over time. Information on the cyclical or episodic nature of the disability and any known or suspected environmental triggers.
- The **credentials of the evaluator/provider** which are relevant to the diagnosed disability. The professional should be licensed or otherwise properly credentialed, have appropriate and comprehensive training, relevant experience, and have no personal relationship with the individual being evaluated or diagnosed.
- **Recommend accommodations, adaptive devices, assistive technology and/or support services** that are logically related to the functional limitation. College disability services office, however, are not under any obligation to provide or adopt recommendations made by outside entities.

Revised and approved by the N.D. Colleges and Universities Disability Service Council: October 2006 AHEAD Best Practices Disability Documentation in Higher Education (2004). Association on Higher Education and Disability.

DISABILITY SERVICES for STUDENTS

MAYVILLE STATE UNIVERSITY

330 3rd St. NE, Mayville, ND 58257 **(701) 788-4675, Voice; Fax: (701) 788-4613**

REQUEST FOR DOCUMENTATION

The student named below has requested accommodations at Mayville State University. In order to be eligible to use accommodations, the student must have a documented disability which substantially limits one or more major life activities as outlined in Section 504 of the Rehabilitation Act and the Americans with Disabilities Act.

Disability Services for Students will use this information to determine reasonable accommodations for this student at Mayville State University.

Student's Name: _____ Date of Birth: _____

Diagnosis (i.e. DSM IV or Medical): _____

Date of Most Recent Evaluation: _____

Name and Title of Evaluator: _____

List diagnostic protocol used: _____

_____

How does this student's disability limit her/him academically?

_____

_____

_____

_____

_____

_____

_____

continued ➡

If this student's disability limits her/him in any other facet of campus life, please explain:

_____

_____

_____

_____

_____

Will the student's limitations change over time? ___No ___Yes, please explain:

_____

_____

_____

Disability Services for Students will consider your recommendations for accommodations when determining the specific accommodations for this student. List any recommendations below and explain how each minimizes or compensates for the functional limitations of the student's disability.

ACCOMMODATION	**HOW IT COMPENSATES FOR THE LIMITATION**

If this student has a learning disability, attach the current psycho-educational evaluation and any other current test results that verify the functional limits of the learning disability.

I certify that the information submitted represents this student's **present level of functioning**.

_____ _____

Signature of Professional *Print Name and Title* *Date*

_____

Organization and Address