Office of Student Accessibility Services

Self-Identification and Impact Statement for Temporary Accommodation Request

Student Accessibility Services works to establish educational accommodations for students who qualify for services in compliance with The American with Disabilities Act and its Amendments as well as Section 504 of the 1973 Rehabilitation Act. The coordinator meets with the student to review their needs and, when deemed reasonable, creates an accommodation plan that is shared with faculty and staff as requested by the student.

Once you provide appropriate medical documentation **and** this Self-Identification and Impact Statement for the disability to the Office of Student Accessibility Services, they will send the accommodation notice to your instructors.

The standard format for medical documentation required by Central Carolina Community College's Office of Student Accessibility Services is as follows:

- Diagnosis from an appropriate licensed professional (with signature)
- Diagnosis on official letterhead with contact information (not on a prescription memo pad)
- Information must be current (within 3 years) and include: diagnosis and symptoms, recommendation for academic accommodations, and a list of all currently-prescribed medications and side effects if not taken as prescribed
    - Information must include treatment, expected duration of condition, and limitations.
- If you have additional documentation, please feel free to submit what you have available for review by the Coordinator of Student Accessibility Services.

It is the student's responsibility to disclose disabilities, provide medical documentation, request accommodations, and schedule test(s).

Name: ____ **Phone:** _____________________

CCCC E-mail Address: __________________________________@cougarmail.cccc.edu

Please indicate the documented disabilities (check all that apply):

❒ Emotional (Psychiatric)	❒ Learning	❒ Orthopedic (Physical)	❒ Visual (Blind/Low Vision)
❒ Hearing	❒ Mental	❒ Speech/Language	❒ Other Health Issue:_____________

Approximately how long will the disability impact you?

How does this disability affect you in an educational setting?

What accommodations are you requesting at Central Carolina Community College? Be specific.

List current medications, if any, you are prescribed (if relevant to disability disclosed):

____

____

Are you taking them as prescribed?

☐ Yes

☐ No

☐ N/A

Consent for Release of Confidential Information

I, ______________________, authorize Central Carolina Community College's Office of Student Accessibility Services Office to discuss (1) the nature of my disability, (2) the particulars of my academic progress, and/or (3) other selected, appropriate information that is deemed necessary to implement accommodations that will provide equal access to Central Carolina Community College's services, activities, and programs.
I provide consent for the following: Please initial your choice(s).

	INITIAL
Parent: ______________________________	_________
Central Carolina Faculty and Staff	_________
Agencies (High school, Voc. Rehab.)	_________
Therapist or Doctor	_________
Other: ______________________________	_________

Agencies or programs of which you are a client or from which you receive support (e.g., Division of Services for the Blind, Vocational Rehabilitation, Department of Veterans Affairs)

Name of **Agency #1:** ____

Address ____

Telephone Number ____

Name of Contact ____

Name of **Agency #2:** ____

Address ____

Telephone Number ____

Name of Contact ____

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I may revoke this consent at any time except to the extent that action has been taken. This authority expires with the completion of all transactions related to services provided by the Office of Student Accessibility Services Office of Central Carolina Community College.

Student signature: _______________________________________ Date: _____________________________

Witness signature: _______________________________________ Date: _____________________________

Student Schedule Request Form

This form must be updated and submitted to the Office of Student Accessibility Services prior to **each semester of enrollment**. Accommodations cannot be provided without this information. If the student's schedule, instructor, or involvement in extracurricular activities change during the semester please notify the Coordinator. For changes to your previous accommodations you will need to speak with the Coordinator in advance. At that point, new medical documentation may be requested. **Remember, you are responsible for meeting with your instructors at the beginning of the semester.** The Coordinator will email you when your plan has been sent to your instructors.

Name: ___________________________ Student ID Number: ________________________

Term (check one):

☐ Fall
☐ Spring
☐ Summer

Year: _______________________

Course Prefix	Course Number	Course Section	Instructor's Name
ENG (Example)	*111 (Example)*	*LO1 (Example)*	*John Smith (Example)*

Extracurricular Activities	Group Contact
Basketball/Phi Theta Kappa (Example)	*John Smith (Example)*

Sign to send accommodation notices to my instructors requesting accommodation

Signature: ____ Date: __________________________