



ADA Release and Statement Form

CALHOUN
COMMUNITY COLLEGE

Name: _____ C Number _____

Address: _____

Phone _____ Email address: _____

I understand that it is my responsibility as a student to communicate with the Student Disability Services/ADA office before the start of each semester to inform them of my new class schedule and list of instructor(s) by completing a new Request for Academic Adjustments and Modifications Form. I may submit my course schedule via email, postal service, or in person. Phone calls will not be permitted. Academic adjustments and modifications are not retroactive and therefore it is best to contact the office before classes begin each semester.

I authorize the Student Disability Services/ADA office to discuss/release the following forms or information to the following people (Please print full names and relationships):

Information to be released:

Academic Adjustments Notification Class Schedule

Student Signature: _____ Date: _____

Student Disability Services/ADA Office Staff Signature & Date: _____

Please note that assessment documentation has to be current.

PSYCHIATRIC DISABILITIES – NO MORE THAN 1 YEAR

ADHD, LEARNING, COGNITIVE, MOBILITY, SENSORY, SYSTEMIC, & TRAUMATIC BRAIN INJURY – NO MORE THAN 3 YEARS OLD



Please return form to Office of Disability Services

Post Office Box 2216 • Decatur, Alabama 35609-2216

Phone 256-306-2630 • Fax 256-260-2447

Student with a Disability: Individual Postsecondary Plan

Name _____ C Number _____ Date of Birth _____

Mailing Address _____

Phone _____ (Cell) _____ (Home) _____

Emergency Contact (Name and phone number) _____

I am enrolled or plan to enroll in the _____ Program
Major Program of Study

What type of disability do you have?

- | | |
|--|---|
| <input type="checkbox"/> (1) Traumatic Brain Injury | <input type="checkbox"/> (8) Seizure Disorder |
| <input type="checkbox"/> (2) Learning Disability | <input type="checkbox"/> (10) Chemical Dependency |
| <input type="checkbox"/> (3) Visual Impairment | <input type="checkbox"/> (11) Psychological Disorder |
| <input type="checkbox"/> Blind | <input type="checkbox"/> (13) AD/HD |
| <input type="checkbox"/> (4) Hearing Impairment | <input type="checkbox"/> (14) Pervasive Developmental Disorder: |
| <input type="checkbox"/> Deaf | <input type="checkbox"/> Autism <input type="checkbox"/> Asperger's <input type="checkbox"/> Tourette's |
| <input type="checkbox"/> (5) Motor/Orthopedic Impairment | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> (6) Chronic Health Problems | |
| <input type="checkbox"/> (7) Speech Impairment | |

Please explain your disability and include a list of necessary medication

How does your disability affect you in a classroom?

As a result of your disability, do you use any type of equipment for everyday living ()Yes ()No
If you answered "yes", what type of equipment do you use? _____

Do you have the required medical or psychological documentation clarifying your disability?
()Yes ()No

Can you climb stairs? ()Yes ()No Do you require parking accommodations? ()Yes ()No

Did you receive accommodations at a previous high school or college? ()Yes ()No

If you answered "yes", where? _____

What type of accommodations did you receive? _____

What type of academic adjustments and modifications would you like to receive? _____

Have you applied to the Division of Rehabilitation Services in your state of residence? ()Yes ()No

If you answered "yes", who is your counselor, and where did you apply? _____

Are you registered with Recordings for the Blind & Dyslexic? () Yes () No

Have you applied for financial aid? () Yes () No

If yes, status of aid: () Approved () Denied () Pending

Documentation is being sent separately by/from: _____

Do you wish to have your classroom instructors notified by the student disability services office that reasonable accommodations are requested? ()Yes ()No

Do you wish to have your clinical/field experience instructors notified by the student disability services office that reasonable accommodations are requested? ()Yes ()No

I authorize/request Calhoun Community College personnel to work on my behalf to arrange Accommodations to help meet my needs as a student at Calhoun.

Student Signature _____ Date _____

For office use only:
This was documented by the
Student Disability Services/ADA
Staff

Signature/Date





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Impairment and Disability Assessment

****TO BE COMPLETED BY A DOCTOR, COUNSELOR, OR CASE MANAGER****

In order for Calhoun Community College to provide disability-related services, we need to establish this student has a disability. A disability is defined as an impairment substantially limiting a major life activity. This form is designed to help us make that assessment. Please respond to the following items:

Student name: _____ Student date of birth: _____

Name of Doctor/Counselor/Case Manager: _____

Facility name and address: _____

Facility phone number: _____

Signature of Doctor/Counselor/Case Manager: _____

Date: _____

I. Impairment Assessment

A. What is the diagnosis/impairment?

B. When was the diagnosis originally made?

C. Is the patient/student currently under your care?

D. When did you last see the patient/student?

E. Is the impairment temporary (<6 months) or persistent?

Continues on back

II. Major Life Activities Assessment

Please check any of the major life activities listed below that are affected as a result of the impairment. Please indicate the level of limitation.

1 – Negligible 2 = Moderate 3 = Substantial

	1	2	3
Caring for oneself			
Talking			
Hearing			
Breathing			
Standing			
Working			
Reaching			
Lifting			
Sitting			
Walking			
Seeing			

	1	2	3
Writing			
Performing manual tasks			
Sleeping			
Learning			
Reading			
Thinking			
Concentrating			
Memorizing			
Taking exams			
Interacting with others			
Other:			

What are the functional limitations resulting from the impairment's impact on major like activities identified in #2 above?

Based upon the major life activities affected by the impairment, are there any accommodations within the context of the community college environment that you can recommend for this student?

"Success for Every Student"



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Phone 256-306-2630 • Fax 256-260-2447

Request for Academic Adjustments and Modifications

Name: _____ C Number: _____ Date of birth: _____

Phone Number: _____ Calhoun email: _____

1. Select term: Fall _____ Spring _____ Summer _____

2. Select appropriate request:

- _____ First time requesting academic adjustments and modifications.
- _____ Request the same academic adjustments and modifications as previous term
- _____ Request to meet with Student Disability Services/ADA staff to discuss different academic adjustments and modifications

3. List information for each course for which you need an accommodation letter:

Class (ex: MATH 100)	CRN (ex: 10543)	Instructor Name
1.		
2.		
3.		
4.		
5.		

4. Your notice will be emailed to your campus email address and to your instructors. You are responsible for discussing your academic adjustments and modifications with your instructor.

5. Review the notice with each instructor and ask each instructor to return the acknowledgement receipt.

_____ I authorize the Student Disabilities Services/ADA office to provide academic adjustments and modifications letter to my instructors.

Student Signature _____ Date _____

It is the policy of the Alabama Community College System and Calhoun Community College, a postsecondary institution under its control, that no person shall, on the grounds of race, color, disability, sex, religion, creed, national origin, or age, be excluded from participation in, be denied benefit of, or be subjected to discrimination under any program, activity, or employment.