



Cleveland State
 COMMUNITY COLLEGE
ACCESS Center
 Student Center • RM 118
 3535 Adkisson Drive • Cleveland, TN 37320
 Phone: (423) 478-6217

Disability Support Services Application

Cleveland State Community College (CSCC) is committed to providing equal access to all programs, services and facilities. Each student's file will be reviewed under the guidelines of Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act (ADA) of 1990. All records will be kept strictly confidential and will not be a part of the student file. The Office of Disability Support Services will review each student's documentation in order to provide an environment in which the civil rights of the student is protected and discrimination is avoided. **It is strongly recommended that all forms and documentation be returned to our office before the start of the semester in order to allow time for processing.**

The Office of Disability Support Services reserves the right to request additional documentation in situations where upon the documentation is deemed incomplete or not current.

What is your intended term of entry: (please check term and indicate year) Fall _____ Spring _____ Summer _____

Are you a new student to CSCC? Yes No Year of High School Graduation or GED _____

Returning CSCC student? Yes No **If yes**, when did you last attend _____

Student's Name: _____ Student ID: N _____

Address: _____

Home Phone: _____ Cell Phone: _____

Current Employment: _____

DOB: _____ Age: _____ Male Female

CSCC Email Address: _____@clevelandstatecc.edu Other Email Address: _____

Emergency Contact _____ Phone: _____

Address: _____

A disability under the ADA is defined as a physical or mental impairment that substantially limits one or more major life activity, a person who has a history or record of such impairment or who is perceived by others as having such impairment.

What is the nature of your disability?

- ADHD Learning Disability Blind Visually Impaired
- Deaf Hearing Impaired Mobility Impaired

Other (please list): _____

What are the functional limitations of your disability? _____

Student Name: _____

ID Number: _____

In your own words, please describe how your disability impacts your daily life and education:

Medications which you are currently taking:

Medication	Dosage	Side Effects <i>Experienced by Patient, if applicable</i>

If yes, counselor's name and phone number

Are you currently a client of Vocational Rehabilitation? Yes No

Name: _____ Phone: _____

Are you requesting temporary or permanent assistance? Temporary Permanent

Completion of this application does not guarantee accommodations. Accommodations are determined by a review of required documentation and the functional limitations your disability imposes outlined therein. Please refer to the guidelines for your specific disability to determine the appropriate documentation.

Signature: _____ Date: _____

Print Name: _____

Please deliver this application and required documentation to:

**Cleveland State Community College
Disability Support Services/ACCESS Center
3535 Adkisson Drive
P.O. Box 3570
Cleveland, TN 37320-3570
Phone: (423) 473-2427 Fax: (423) 614-8724**



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Consent Form

Confidentiality and Release of Information

The Office of Disability Support Services and the Cleveland State Community College ACCESS Center is committed to protecting the confidentiality of student records in our possession. We retain student records in compliance with both state and federal law, in particular, with the **Family Education Rights and Privacy Act (FERPA)**.

I, _____ hereby authorize the Office of Disability Support Services at Cleveland State Community College to communicate with the following as needed.

Please initial any or all that may be appropriate:

- _____ Parent or guardian: Name(s): _____
- _____ Faculty/Staff and other campus services (*i.e. Student Services, Financial Aid, etc.*)
- _____ Off-Campus Services (*i.e. professional, college, Vocational Rehabilitation, etc.*)
- _____ Other (*please specify*): _____

Communication as denoted above may include obtaining and/or releasing student's historical and/or current information regarding assessment, diagnosis, needs, recommendations, treatment, prior services, academic records, performance, or information that may relate to accommodating the student's needs on Cleveland State's campus.

Signature: _____ Date: _____

Print Name: _____

***This consent will be valid until revoked by the student.
A photocopy of the original consent form shall be as valid as the original consent form.***



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Student Request for Accommodations Planning Form

This form is a planning tool used when requesting accommodations. The information provided below is strictly confidential and will not be shared without your permission. **Requests for accommodations MUST be supported by documentation.** Students will be contacted regarding their eligibility status through their Cleveland State e-mail accounts. Students requesting accommodations must meet with the Coordinator of Disability Support Services to develop an accommodation plan.

Student's Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Student's ID Number: N _____ VR Counselor: _____

Past **educational accommodations** that you have used successfully *(please specify)*? _____

What **classroom accommodations** are you requesting?

What **testing accommodations** are you requesting?

What **other accommodations** are you requesting?

Please return completed form to:

Disability Support Services/ACCESS Center
 Cleveland State Community College
 3535 Adkisson Drive, P.O. Box 3570
 Cleveland, TN 37320-3570
 Phone: (423) 472-7141 (800) 604-2722 Fax: (423) 478-6255
mvandyke@clevelandstatecc.edu