Goodwin University

OASR

Office of AccessAbility Services Registration

Application Date: _____

PERSONAL INFORMATION

Full Name: _____ Legal Name (if different): _____

Student ID Number: _____ Date of Birth: _____

Gender Identity: _____ Preferred Pronouns: _____

Mailing Address: _____

Email Address: _____ Phone Number: _____

Are you a veteran or active military member? ☐ Yes ☐ No

Briefly describe why you are contacting the Office of AccessAbility Services (OAS):

HOW WERE YOU REFERRED TO OAS? *Check all that apply*

☐ Advising Offices
☐ Career Services
☐ Dean of Students
☐ Family
☐ Friend
☐ Medical Doctor
☐ Professor
☐ Residence Life
☐ Self
☐ Student Health Services
☐ Counseling Services
☐ Other _____

DISABILITY CATEGORY *Check all that apply*

☐ ADHD
☐ Allergy
☐ Autism Spectrum Disorder
☐ Blindness/Low Vision
☐ Chronic Health Condition
☐ Communication Disorder
☐ Deaf/Hard of Hearing
☐ Learning Disability
☐ Mobility impairment (temporary or permanent)
☐ Multiple Chemical Sensitivity
☐ Neurocognitive Disorders (TBI/ Concussion, etc.)
☐ Neurological condition
☐ Psychiatric/Mental Health Impairment
☐ Seizure Disorder
☐ Speech/Language Impairment
☐ Unsure

Formal Diagnosis/es: _____

Please describe your disability and how it currently impacts major life activities (Eating, Walking, Seeing, Hearing, Speaking, Breathing, Working, Performing Manual Tasks, Learning, Standing, Sleeping, Reading, Concentrating, Thinking, Communicating etc.)

Have you ever received accommodations before? ☐ Yes ☐ No

If yes, please describe:

Do you or have you used any adaptive technology or devices? If so, please describe what has been the most helpful:

Please list the accommodations that you feel are necessary to allow you to access our curriculum and community and how each relates to your experience of your disability.

DOCUMENTATION REQUIREMENTS

In determining reasonable accommodations, we consider each student's experience, history, request and the characteristics of each Goodwin course and program. Students are a vital source of information. In many cases, to guide the process and to help determine reasonable and appropriate accommodations, we may request information from other sources in order to establish the connection between the disability and the barrier.

For documentation guidelines, click here or contact OAS.

CERTIFICATION AND AUTHORIZATION

Under the Family Educational Rights and Privacy Act (FERPA), OAS may share information and communicate with appropriate University personnel on a need-to-know basis in order to facilitate the process of determining accommodation eligibility and/or implementation. In limited circumstances, specific information may be required to be disclosed in order to protect individuals in an emergency or to comply with law and/or University policies and procedures.

☐ I give permission for the Office of AccessAbility Services to speak with or request information from the treating professional providing documentation (if not attached) to support my accommodation request(s) if needed to make a decision.

I understand that this authorization is voluntary. ☐ Yes ☐ No

If yes: This authorization will expire 180 days from the date on which I sign below. I understand that I may revoke this authorization at any time by providing written notice to OAS.

NAME OF PROFESSIONAL(S) AND CONTACT INFORMATION:

_____

_____

_____

DISCLOSURE INFORMATION

☐ I certify that the information entered on this form is accurate. I understand that my accommodation request(s) cannot be considered until appropriate documentation is submitted. I understand that disclosing a disability at this time does not necessarily confirm eligibility for services or accommodations. I understand that the Office of AccessAbility Services will make every attempt to quickly review all requests for accommodations, the verification process may take several weeks or longer, depending upon the complexity of the request.

☐ I understand Goodwin's use of the information on this form as stated above. If I responded affirmatively above, I am giving permission for my treating professional to be contacted, if necessary, to determine accommodation eligibility.

Student Signature: Date:

OAS Coordinator Signature: Date: