Testing and Disability Services
Division of Student Affairs
Phone: 706.737.1469
Fax: 706.729.2298
E-Mail: tds@augusta.edu

Personal Information

Name: _____ _____
First Middle Last Preferred Name

Date of Birth: _____ **Student ID #:** _____ **Referred By:** _____

Gender: _____ **Race:** _____ **Veteran?** □ **Yes** □ **No**

Address: _____
Street

_____
City State Zip code

Telephone: _____ _____ _____
Cell Phone Other E-Mail Address

Are you currently receiving services from Vocational Rehabilitation? _____

If yes, name of counselor: _____

Emergency Contact Name: _____

Relationship: _____ **Phone Number:** _____

Academic Information

□ Freshman □Sophomore □Junior □Senior □Graduate

□ Medical College of Georgia □Dental College of Georgia

Major: _____ **First Semester at AU:** _____

Transfer Students:
Previous College Attended: _____

Anticipated Enrollment Date: _____ **Year:** _____
Semester (Spring, Fall, Summer)

Disability Information

Check all that apply:

- ☐ Attention Deficit Hyperactivity Disorder (ADHD)
- ☐ Brain Injury
- ☐ Chronic Health Condition
- ☐ Deaf/Hard of Hearing
- ☐ Learning Disability
- ☐ Other
- ☐ Mobility Impairment
- ☐ Neurological Condition
- ☐ Psychological Condition
- ☐ Visual Disability
- ☐ Asperger's Syndrome

Disability Diagnosis: _____

Date of Onset: _____ **Date of Diagnosis:** _____

Current Medications: _____

Please describe the impact of your disability in an academic environment: _____
_____
_____
_____

Accommodations

What accommodations have you used in the past?

High School: _____
_____
_____

Previous Colleges: _____
_____
_____

List the accommodations you are requesting: (e.g., test accommodations, note-takers, van service) _____
_____
_____

Release of Information to Parent/Guardian

Parent/Guardian Name(s):

_____

_____

Address: _____

Phone #: _____

I understand that by signing this form, I authorize the office of Disability Services to discuss or release to the above parent/guardian information regarding my disability to assist in the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Testing and Disability Services. The revocation will not apply to action taken prior to that date.

Date signed: _____ **Student Signature:** _____

Print Name: _____

Release of Information for Faculty/Staff

I, _____, hereby understand that by signing this form. I authorize the office of Testing & Disability Services to discuss or release to AU faculty/staff information regarding my disability to assist in providing reasonable accommodations.

The purpose of this disclosure is for the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Testing and Disability Services. The revocation will not apply to action taken prior to that date.

Date signed: _____ **Student Signature:** _____

Print Name: _____