CALHOUN COMMUNITY COLLEGE

Student Disability Services/ADA
PO Box 2216, Decatur, AL 35609
Phone 256-306-2630 • Fax 256-260-2447

Decatur Campus
Chasteen Student Services Building
Room 220

Huntsville Campus
Sparkman Building Advising Center
Room 101 E/C

Request for Academic Adjustments and Modifications

Name: _____ **Student ID#:** _____ **Date of birth:** _____

Phone Number: _____ **Calhoun email:** _____

1. **Select ONE term:** Fall _____ Spring _____ Summer _____
   Please submit this form each semester you would like to request accommodations. Accommodations are not retroactive.
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. **Your ADA letter will be emailed to your Calhoun email address.**

4. **Select one of the options below:**

   _____ I authorize the Student Disabilities Services/ADA office to provide my ADA letter to my instructor(s).

   _____ I do not authorize the Student Disabilities Services/ADA office to provide my ADA letter to my instructor(s).

5. **I authorize the Student Disability Services/ADA office to discuss/release information to the following people (Please print full names & relationships).**

   _____ _____

6. **I authorize the Student Disability Services/ADA office to discuss/release information to:**
   ___ Testing Center ___ STAR Institute

7. **Your instructor will contact you regarding the use of academic adjustments in your course.** If your instructor does not contact you within five (5) days of receipt of your letter, please notify the Student Disability Services/ADA Office.

8. **If you review your ADA letter with your instructor(s), ask each instructor to return an acknowledgement receipt.**

Student Signature _____ Date _____

DISCLAIMER: **By typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.** 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.

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Please Return Form To:

STUDENT DISABILITY SERVICES/ADA
P.O. Box 2216 | Decatur, AL 35609
(256) 306-2630 | Fax: (256) 260-2447

STUDENT WITH A DISABILITY:

Individual Postsecondary Plan

Student Name: _____ ID #: _____ Date of Birth: _____

Mailing Address: _____

Phone: _____ Email: _____

Please describe your disability and include a list of necessary medication(s):

_____

_____

Did you receive accommodations at a previous high school or college? ☐ YES ☐ NO

If you answered "YES", then where? _____

What type of accommodations did you receive?

_____

_____

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

_____

_____

Do you wish to have your clinical/field experience instructors notified by the Student Disability Services/ADA Office that reasonable accommodations are requested? ☐ YES ☐ NO

Student Signature: _____ Date: _____

DISCLAIMER: By typing your name above, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

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Impairment and Disability Assessment

******TO BE COMPLETED BY A DOCTOR, LICENSED COUNSELOR, OR MEDICAL PROFESSIONAL******

In order for Calhoun Community College to provide disability-related services, we need to establish this student has a qualifying 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: _____ Date of Birth: _____

Name of Doctor/Licensed Counselor/Medical Professional: _____

Facility Name and Address: _____

_____

Phone: _____ Date: _____

Signature of Medical Professional _____

I. Impairment Assessment

1. What is the diagnosis/impairment?

_____

2. When was the diagnosis originally made?

_____

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

_____

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

_____

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

_____

(Continued on back)

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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	☐	☐	☐
Speaking	☐	☐	☐
Hearing	☐	☐	☐
Breathing	☐	☐	☐
Standing	☐	☐	☐
Working	☐	☐	☐
Eating	☐	☐	☐
Lifting	☐	☐	☐
Walking	☐	☐	☐
Seeing	☐	☐	☐

	1	2	3
Bending	☐	☐	☐
Performing manual tasks	☐	☐	☐
Sleeping	☐	☐	☐
Learning	☐	☐	☐
Reading	☐	☐	☐
Thinking	☐	☐	☐
Concentrating	☐	☐	☐
Communicating with others	☐	☐	☐
Other:	☐	☐	☐
Other:	☐	☐	☐

What are the functional limitations resulting from the impairment's impact on major life activities identified in the assessment above?

_____

_____

_____

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

_____

_____

_____