Student Disability Services
Request for Academic Adjustments and Modifications

Email: ada@calhoun.edu Fax: 800.783.8484 Phone: 256.306.2630

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.

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 staff to discuss different academic adjustments/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 and relationships)

_____ _____

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

7. It is essential that you reach out to your respective faculty members within the first five days of the course to arrange a discussion regarding your academic accommodations. This proactive approach ensures that necessary adjustments can be made in a timely manner to support your academic journey effectively.

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

Student Signature _____ Date _____

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

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Address: PO Box 2216, Decatur, AL 35609

Impairment and Disability Assessment

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

For Calhoun Community College to provide disability-related services, we need to prove the student, whose name is listed below, has a qualifying disability. A disability is defined as an impairment sustainably limiting a major life activity. This form is designed to help make that assessment.

Student Name: _____ Date of Birth: _____

Please respond to the following items:

Impairment Assessment:

What is the diagnosis/impairment? Please include DSM-V or ICD-10:

_____

Is the student currently under your care? _____ Date of last visit: _____

Check any of the major life activities listed below that are sustainably affected because of the impairment.

Self-Care		Speaking		Lifting	
Learning		Hearing		Walking	
Reading		Visual		Eating	
Thinking		Breathing		Bending	
Concentrating		Standing		Manual Tasks	
Communicating		Working		Sleeping	

Duration of Disability: ☐Permanent/Chronic ☐Temporary, estimated duration _____

Condition is: ☐Stable ☐ Prone to exacerbations

Based upon the major life activities affected by the impairment, what accommodations (within the context of the community college environment) would you recommend for this student? If needed, use the back of the page.

_____

_____

_____

I understand that the information provided in this form will become part of the student record subject to the federal Family Education Rights and Privacy Act (FERPA) of 1974 and may be released to the student upon written request.

Signature of Licensed Professional: _____

Printed Name: _____ License #: _____

Facility Name & Address: _____

Phone_____ Today's Date: _____

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