Date _____

DOE_____

APPLICATION FOR DISABILITY SERVICES

Name_____Student ID_____
First Last Middle Initial

Address_____ City_____ ST___ Zip Code_____

Phone No. (H) (____)_____ (W) (____)_____ E-Mail _____

Live on Campus? Yes _____ No _____ N/A _____

Date of Birth _____ Male ___ Female ___ Emergency Contact_____

Student _____ Major _____ Employee _____ Dept._____

Classification: Freshman ___ Sophomore ___ Junior ___ Senior ___ Graduate ___ N/A ___

Explain your disability and current treatment:_____

_____

_____

_____

What accommodations are you requesting?_____

_____

_____

_____

Do you take prescription medication? Please name it, the dosage and the physician who prescribed it.

_____

_____

Services or any other agency? If you answered yes, please name your counselor or contact person and his/her location._____.

Once you make application for services and provide the appropriate documentation, the Disability Services Coordinator/Director of Human Resources will review your documentation and inform you of your status as a student or employee with a disability.

Permission to Release Information

I_____, hereby give my permission to Troy University to
Print Name
discuss information concerning my disability and accommodations and/or to release documentation on my disability, with individuals who will be involved in the delivery of services to me for my benefit. I also give permission for other agencies and individuals to discuss and release information to the Troy University Disability Services Coordinator. In addition, pertinent

TROY UNIVERSITY
Disability Services Accommodation Letter

Memorandum to Faculty:

The student/employee listed below has registered with the Disability Services Coordinator/ Director of Human Resources as having a documented disability that will require accommodations. This means that (s)he is eligible for services that give equal access to higher education/
employment under the guidelines of Section 504 of the Rehabilitation Act of 1973 (as amended) and the Americans with Disabilities Act of 1990. Please discuss these accommodations with the student/employee and immediately contact the Disability Services Coordinator/Director of Human Resources if there are any concerns.

Troy University is committed to ensuring that all information regarding a student/employee is maintained as confidential as required or as permitted by law. Information in files will not be

federal or state law.

Student/Employee Name_____

Student ID:_____

Term and Year:_____

Accommodations Approved:_____

_____

_____

_____

_____

_____

_____

_____

_____

For more information, please contact the Disability Services Coordinator or Director of Human Resources on your campus.

TROY UNIVERSITY
ADA GRIEVANCE FORM

Complainant:
Date: _____
Name: _____ Signature:_____

Mailing Address:_____

Home Phone # (____)_____ Work Phone # (____)_____

Faculty _____ Staff _____ Student _____ Other (specify) _____

Respondent:

Name of person or group the complaint is against: _____

Phone # (____)_____

Faculty _____ Staff _____ Student _____ Other (specify) _____

What was the result of your discussion with the respondent? (Please use back if additional space is necessary)
_____

_____

Complaint Details:
Date and Time: _____ Location: _____

What happened? _____

_____
(Please use back of form if additional space is necessary)

Names and phone numbers of others who can verify what happened:
_____

What would you like to see happen (for you, for others) with respect to this issue?

_____

_____

OFFICE USE ONLY

Actions Taken: _____

_____