

# Disabilities\* Disclosure Form

OPTIONAL



Wells College

This form should be completed when a student has indicated his or her desire to request reasonable accommodation(s)<sup>†</sup> from the college for a learning, physical or psychological disability.

- **Upload** the form to your Status Page [apply.wells.edu/apply/status](http://apply.wells.edu/apply/status)
- **Mail** the form and supporting medical documentation to the Admissions Office at **170 Main Street, Aurora, NY 13026**
- **Fax** the form and supporting medical documentation to the Admissions Office at **(315) 364-3227**

Please make copies of this form for your records and to give to your health care providers so that they may release your records to the College.

STUDENT FULL NAME (please print) \_\_\_\_\_

HOME PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_ CELL PHONE NUMBER (\_\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

*Attach a complete evaluation report that addresses these concerns or complete the information below.*

Identify and describe the physical, learning or psychological disability, illness, condition or disease that is the basis for your request for reasonable accommodation(s) by the college. Be specific:

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Describe how this disability affects your academic work, class schedule, class location and/or residential living situation:

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Identify and describe the reasonable accommodation(s) needed to enable you to meet or perform the academic standards of your educational program. (If you require specific housing accommodation, please submit the housing exemption request.)

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Identify and describe any equipment, aids and/or services that you currently use and are willing to provide and/or utilize:

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\* **Disability** includes a physical or mental impairment that substantially limits one or more major life activities. Major life activities include such things as caring for oneself, performing manual tasks, walking, sitting, standing, lifting, reaching, seeing, hearing, breathing, learning and working.

† **Reasonable Accommodation** includes any modification or adjustment or educational environment of the college to enable an applicant or student, to meet and perform requisite academic standards and to enjoy equal benefits and privileges of education.

**CONSENT TO RELEASE INFORMATION**

Information concerning your disability will be treated confidentially and will be shared with staff and faculty at the college who have a legitimate educational interest.

**Yes**, I request assistance in arranging for my reasonable accommodation(s) and I give Wells College permission to share information concerning my disclosed disability and request for reasonable accommodation(s) with campus professionals who have a legitimate educational interest and to work with the Coordinator of Student Achievement to complete an Accommodation Plan to give to my professors and advisor and other appropriate campus officials.

**No**, I am not requesting accommodations at this time.

I understand that Wells College will circulate among my faculty and other relevant parties confidential information about my disability and about reasonable accommodations that might be made to facilitate my success only if I give my permission. I agree to the option I have initialed below:

\_\_\_\_\_ **I GIVE PERMISSION** to Wells College to release information about my disability to  
INITIAL faculty of courses in which I am enrolled and to other relevant parties

\_\_\_\_\_ **I DENY PERMISSION** to Wells College to release information about my disability.  
INITIAL

\_\_\_\_\_  
SIGNATURE OF STUDENT DATE

*(This signature gives/denies permission until revoked in writing.)*

**Please attach appropriate documentation such as neuropsych evaluations and medical documents, along with a psychological/educational evaluation report to support your request, including names and addresses of physicians, therapists, psychologists or other health care providers who have information concerning your disability.**

NAME, ADDRESS, PHONE, E-MAIL AND FAX OF HEALTH CARE PROVIDERS:

\_\_\_\_\_  
\_\_\_\_\_

I hereby authorize the above-listed health care providers (and any others who have treated me) to release to Wells College all medical records concerning the disability disclosed herein and to provide any opinions to the college concerning my ability to (1) meet and perform the academic standards requisite to performance of the educational program or activity that is the subject of this request and (2) to enjoy equal benefits and privileges of education as are enjoyed by other similarly situated students without disabilities.

I certify that I have read, reviewed and been informed of the academic requirements as outlined in the Wells College Catalog and further certify that the foregoing statements are complete, accurate and true to the best of my knowledge.

I also understand the college may require me to undergo further testing for the purpose of establishing existence and/or extent of my disability, illness, condition or disease and my need for reasonable accommodation(s).

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SIGNATURE OF STUDENT DATE