

UCR Services for Students with Disabilities

STUDENT DATA SHEET & REQUEST FOR ACCOMMODATIONS

Personal Information

Full Name: _____
Last *First* *Middle*

Local Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Home Phone: () _____ Cell Phone: () _____

UCR E-mail Address: _____

Permanent Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Permanent Phone: () _____

Student Information

Student ID: **860-** _____

Class Level: **Freshman** **Sophomore** **Junior** **Senior** **Grad** **Other**

Major: _____

Expected Quarter & Year of Graduation: _____

Disability Information

How did you hear about our services? _____

What is your disability? _____

Please list accommodations requested? _____

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Student Disability Verification: I agree to provide the Student Special Services Office at UCR with authorized documentation of my disability. This shall be certified by a licensed physician, psychologist, audiologist, speech pathologist, physical therapist, corrective therapist, learning disabilities specialist, or rehabilitation counselor. I understand this information will be strictly confidential and will be used only for the purposes of program planning and reporting. I authorize the person and/or agency named below to release such information to the UCR Student Special Services Office. A photostatic copy of this authorization shall be deemed as effective and valid as the original.

Student
Signature: _____
signature *Date*

Witness
Signature: _____
signature *Date*

I received treatment for this condition from: **My Own Physician** **UCR Student Health Service**

Name: _____

Address: _____

Phone: () _____

FOR OFFICE USE ONLY
SID _____
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Department of Rehabilitation or Veterans' Administration Clients Only

I grant the Student Special Services Office at the University of California, Riverside, permission to obtain medical verification of disability from the State Department of Rehabilitation or from the Veterans' Administration. I understand that this information will be considered strictly confidential and will be used only for the purposes of program planning and reporting. In addition, I request and authorize Services for Students with Disabilities to release to the State Department of Rehabilitation or to the Veterans' administration, pertinent information written socially, educationally, medically or vocationally while attending UCR.

Student
Signature: _____
signature *Date*

Witness
Signature: _____
signature *Date*

Vocational Rehabilitation Counselor: _____

Address: _____

Phone: () _____