Testing and Disability Services
Division of Student Affairs
Phone: 706.737.1469
Fax: 706.729.2298
E-Mail: tds@augusta.edu

Personal Information

Name: _____ _____
First Middle Last Preferred Name

Date of Birth: _____ **Student ID #:** _____ **Referred By:** _____

Gender: _____ **Race:** _____ **Veteran:** □ **Yes** □ **No**

Address: _____
Street

_____
City State Zip code

Telephone: _____ _____ _____
Cell Phone Other AU E-Mail (other, if not admitted)

Are you currently receiving services from Vocational Rehabilitation: _____

If yes, name of counselor & VR office state/county: _____

Emergency Contact Name: _____

Relationship: _____ **Phone Number:** _____

Academic Information

□ Freshman □Sophomore □Junior □Senior □Graduate □Post-Baccalaureate

□ Medical College of Georgia □Dental College of Georgia

Major: _____ **When is/was your first semester at AU:** _____

Where is your main campus (Athens, Health Sciences, Summerville, etc.): _____

Previous College(s) Attended: _____

Which semester and year will you start classes: _____

Disability Information

Check all that apply:

□ Attention Deficit Hyperactivity Disorder (ADHD) □ Mobility Impairment □ Chronic Health Condition

□ Visual Disability □ Deaf/Hard of Hearing □ Learning Disability □ Psychological Condition

□ Brain Injury (Acquired/Traumatic) □ Neurological Condition (Seizures, Brain tumor, etc.)

□ Autism Spectrum Disorder □ Other: _____

Disability Diagnosis: _____

Date of Onset: _____ **Date of Diagnosis:** _____

Current Medications: _____

Please describe the impact of your disability in an academic environment: _____

_____

_____

_____

Accommodations

What accommodations did you have in high school: _____

_____

_____

What accommodations did you have at any previous colleges: _____

_____

_____

List the accommodations you are requesting (e.g., test accommodations, audio record lectures, etc.):

_____

_____

_____

Release of Information to Parent/Guardian

Parent/Guardian Name(s): _____

_____

_____

Address: _____

Phone #: _____

I understand that by signing this form, I authorize the office of Disability Services to discuss or release to the above parent/guardian information regarding my disability to assist in the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Testing and Disability Services. The revocation will not apply to action taken prior to that date.

Date signed: _____ **Student Signature:** _____

Print Name: _____

Release of Information for Faculty/Staff

I, _____, hereby understand that by signing this form. I authorize the office of Testing & Disability Services to discuss or release to AU faculty/staff information regarding my disability to assist in providing reasonable accommodations.

The purpose of this disclosure is for the determination and implementation of reasonable accommodations and to address educational planning needs.

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Testing and Disability Services. The revocation will not apply to action taken prior to that date.

Date signed: _____ **Student Signature:** _____

Print Name: _____