Hardin-Simmons University
Office of Disability Services
Sandefer Memorial, Room 107
HSU Box 16158
Abilene, TX 79698
325-670-5842
Fax: 325-670-5862
disabilityservices@hsutx.edu

For HSU Office Use Only:

Date received: _____

APPLICATION FOR TEMPORARY DISABILITY SUPPORT SERVICES

Today's Date:_____

Name_____ _____ _____ _____ _____
Last First Middle (Maiden) (Preferred)

SS# _____ Date of Birth ____/____/____ HSU ID_____ M☐ F☐

Classification Please Select

HSU Email Address:_____
*all correspondence from the Office of Disability Services will go to your HSU email address

Local Address **Permanent Address** (if different from local)

Phone_____ _____
cell other

Emergency Contact Name_____

Address_____

Phone_____

Please attach a signed diagnostic statement on official letterhead from your treating professional that includes the following information:

1. **Diagnosis; date of onset; original diagnosis; and description of present symptoms**
2. **Description of the expected progression or stability of the condition/disability**
3. **Current treatment plan**
4. **Description of the current functional impact on the student within the academic setting**
5. **Recommended accommodations**
6. **Credentials of the diagnosing professional including certification, licensure, professional training, etc.**

AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

I, _____, understand that in order for the Office of Disability Services to verify my disability and determine appropriate accommodations, pertinent evaluations, psychological reports, transcripts, and medical reports must be obtained. I understand that this form must be signed in order for this information to be gathered and reviewed by the HSU Office of Disability Services. Without this documentation, my application will be considered incomplete.

I understand that no one other than the HSU Disability Coordinator and designated personnel of the Disability Office will have immediate access to my file. Any information regarding my disability shall be considered confidential and will only be shared with others within the institution on a need-to-know basis. I further understand that my file will not be released by the HSU Office of Disability Services except in accordance with federal and state laws. Therefore, for the purposes noted above and in accordance with the conditions specified, I hereby authorize release of information from my reports to authorized personnel at Hardin-Simmons University and its Office of Disability Services.

_____ _____

Signature Date

OPTIONAL: I give my permission for the HSU Office of Disability Services to discuss my academics as related to my disability with my parents or legal guardian(s).

_____

Parent Name(s)

_____ _____

Signature Date

How did you hear about our services?

ADA statement on course syllabus ☐ HSU Website ☐ Instructor ☐ Advisor ☐ Parent ☐

HSU catalog ☐ Another student ☐ Other_____

For your benefit, please maintain a copy of all documentation submitted to the HSU Office of Disability Services. Documentation that has been submitted cannot be released back to you (except where permitted by law).

Return this application to:

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