



Office of Disability Services

Student Intake Form

Please submit the appropriate disability verification with this form. See guidelines for documentation on our website at <http://www.westmont.edu/offices/disability/>.

If you have any questions, please contact us directly at 805-565-6135, 805-565-6186 or email ods@westmont.edu. Our offices are located upstairs in the Library VL 311 and 310A.

PERSONAL INFORMATION: (Please print clearly or attach typed document) DATE _____

Name _____	Westmont I.D. # _____
Address _____	Residence Hall _____
_____	Email _____
City _____ State _____	Westmont Email _____
Zip Code _____	Cell # _____

ACADEMIC STATUS

First Year _____ Second Year _____ Third Year _____ Fourth Year _____ Other _____

Are you a transfer student? No _____ Yes _____

The DOCUMENTATION I will submit verifies that I have the following disability: (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Deaf/Hard of Hearing |
| <input type="checkbox"/> ADHD (with or without hyper-activity) | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Mobility Impairment | <input type="checkbox"/> Psychological Impairment |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Chronic Health Impairment |
| <input type="checkbox"/> TBI (Traumatic Brain Injury) | _____ |
| <input type="checkbox"/> Speech/Communication Impairment | <input type="checkbox"/> Other _____ |

2. Briefly describe **YOUR** understanding of your current impairment and any relevant diagnosis.

3. When were you first diagnosed with the condition you consider disabling? If more than one, list them separately?

4. Describe how your condition(s) or impairment(s) impact your functioning in a college setting and any difficulties you are having.

5. What accommodations are you requesting at Westmont College?

6. Describe in detail the accommodations you have received in the past, including the nature of the accommodation(s), the name of the providing institutions, and dates provided.

7. When and by whom were you recently evaluated/treated for the condition(s) that cause your impairment?

I have read and understand the following information (please check each):

- Documentation Requirements <https://www.westmont.edu/disability-services/documentation-requirements>
- Grievance Procedures <https://www.westmont.edu/disability-services/disability-services-grievance-procedure>
- Student Rights and Responsibilities <https://www.westmont.edu/disability-services/disability-services-rights-and-responsibilities>

A review of your documentation relating to your request will begin after this form and all supporting documentation have been received. The review process can take up to 14 days. **Please do not send original copies of documentation. We do not return materials once submitted.**

By signing below, you are initiating your request to be established as a student with a disability in accordance with federal and state regulations.

Signature of Student _____ Date _____

Email, fax or mail forms to: Office of Disability Services, Westmont College, 955 La Paz Rd, Santa Barbara, CA. 93108 Attn: Sheri Noble ~ ods@westmont.edu ~ FAX 805-565-7244



CONSENT TO RELEASE INFORMATION FROM EDUCATIONAL RECORD FOR:

Student's Name (First, Middle, Last)

Westmont Student ID #

INFORMATION TO BE RELEASED:

In accordance with the college's policy on the Family Educational Rights and Privacy Act of 1974, I provide this written authorization for the release of information from my educational records as provided below. I understand that the individuals I've authorized will be required to verify their identity by providing the last four digits of their Social Security Number. I also understand that I may revoke this authorization at any time by signing and returning the revocation form below the office(s) maintaining the requested records.

MY EDUCATIONAL RECORD INFORMATION FROM THE OFFICES LISTED BELOW MAY BE RELEASED TO:

Name (First, Middle, Last)

Phone # (or last 4 digits of Social Sec.#)

Name (First, Middle, Last)

Phone # (or last 4 digits of Social Sec.#)

PURPOSE OF DISCLOSURE _____ (why do you want the information released to those listed above?) **Examples: to assist in planning courses for an academic term; allow my Student Life situation to be discussed.**

THE FOLLOWING OFFICE(S) MAY RELEASE INFORMATION FROM MY EDUCATIONAL RECORD TO THE INDIVIDUAL(S) NAMED ABOVE:

- Records Office:** for information such as grades, enrollment status, courses, transcript
- Student Life:** for information such as student care or conduct records, other Student Life information. Does not include Counseling and Psychological Services (CAPS) or Health Center records
- Office of Disability Services:** for information such as disability and accessibility information
- Other Office:** _____

Student's Signature

____/____/____
Month Day Year

*For release of information forms for the Financial Aid or the Business Office, please contact those offices directly.

REVOCACTION:

By signing below, I revoke this authorization. I understand that my information will no longer be provided to the individual(s) named above.

Student's Signature

____/____/____
Month Day Year

Return this form to the office for which release of information authorization is granted. Contact Student Life with questions: stulife@westmont.edu 805.565.6028 ~Westmont College, 955 La Paz Road, Santa Barbara, CA 9310

