



WASHINGTON COLLEGE  
ADA DISCLOSURE FORM

Please complete this form if you desire to disclose a learning, physical, health, or psychological disability. Once completed (and if so indicated at the bottom of this form), the college will determine whether or to what extent to provide reasonable accommodations.

Full Name \_\_\_\_\_ Student ID Number: \_\_\_\_\_

Home Phone Number \_\_\_\_\_ E-mail \_\_\_\_\_

Student's Cell Number \_\_\_\_\_ Parent's Cell Number \_\_\_\_\_

Permanent Address \_\_\_\_\_

Academic Standing:  Incoming New Student  First Year  Sophomore  Junior  Senior  Transfer

**Please describe the accommodations, and/or services you have used in the past and why you believe they are necessary in a post secondary academic setting: Please attach a separate sheet if necessary.**

Medical (i.e. wheelchair accessibility):

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Counseling Services (i.e. weekly meetings with psychologist):

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Classroom Accommodations (i.e. extended time):

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In providing this information, I acknowledge the disclosure of my disability to Washington College.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Information concerning your disability will be treated confidentially and will be shared with staff at the college on a "need to know basis." By checking "Yes" below and signing this form, you give Washington College permission to share information concerning your disclosed disability and your request for reasonable accommodation(s) with campus professionals who "need to know". These professor(s), adviser(s), and/or counselor(s) will work with you to complete an academic Accommodation Plan.

- Yes, I am requesting reasonable accommodation(s).**
- No, I am not requesting accommodation(s) at this time.**

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

Continue on Reverse

**PLEASE ANSWER THE FOLLOWING QUESTIONS IF YOU ARE REQUESTING ACCOMMODATIONS:**

**Identify and describe any equipment, aids and/or services that may be needed to fulfill the above accommodation(s):**

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**Please check:**

I received special education services in high school.       Yes       No

I was exempt from foreign languages in high school.       Yes       No

I transferred from another college or university.       Yes       No

If yes, from where? \_\_\_\_\_

I am a consumer of Vocational Rehabilitation or Bureau of Services for the Visually Impaired.       Yes       No

If yes, what is your counselor's name and phone number? \_\_\_\_\_

Yes, I have attached or submitted professional documentation which supports my request (see attached).

No, I have not attached or submitted professional documentation at this time. I understand that it is my responsibility to submit or arrange for the submission of documentation which supports my request and that accommodations may not be granted until approved documentation has been submitted and reviewed by an appropriate Washington College official.

**Following are names, addresses and phone numbers of physicians, therapists, psychologists or other health care providers that Washington College may contact concerning my disability:**

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I understand that this form must be submitted with professional documentation to the appropriate College Official prior to a pre-service interview. During this meeting we will identify and enumerate services for which I am eligible. The information submitted to Washington College will not be placed in my educational records.

I hereby authorize the above listed health care providers to release to Washington College Health Services and Counseling Center 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) enjoy equal benefits and privileges of education as are enjoyed by other similarly situated student's without disability.

I certify that I have read, reviewed and been informed of the academic requirements as outlined in the Washington College catalog. I further certify that the foregoing statements are complete, accurate and true to the best of my knowledge. I also understand that the college may require of me further testing for the purpose of establishing the existence and/or extent of my disability, illness, condition or disease and my need for reasonable accommodation(s).

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Washington College Official: \_\_\_\_\_ Date: \_\_\_\_\_

Please make copies of this form for your records and your health care providers so that they may release your records to the college. Mail this form and any associated documentation to:

Washington College Health Services  
300 Washington Ave  
Chestertown, MD. 21620  
Fax: 410-810-7101