



DISABILITY SUPPORT SERVICES REGISTRATION PACKET

Dear Student:

This cover letter is to inform you of the policy in place at The George Washington University regarding services for students with disabilities. In order to access any accommodations/services as a student at The George Washington University, you are required to register with the Office of Disability Support Services. **Please note the completion of this form alone does not insure access**, but serves as your statement of disclosure of a disability to request consideration. Keep this cover page for your records before submitting the attached form. It must be accompanied by documentation that fulfills the criteria set forth by the ADA and Section 504 of the Rehabilitation Act, and this institution, in order to complete the process.

Eligibility for specific accommodations/services available is determined based upon the review of that documentation which must substantiate the presence of a disability and assess its current impact on student performance. This information enables DSS staff to work more effectively in the provision of necessary supports. You should note that the records kept in our office are strictly confidential and are not a part of a student's academic record.

You are urged to set up an appointment to review your personal situation. Please visit our web site at www.gwired.gwu.edu/dss for further information.

We look forward to working with you and wish you great success at GW!

Sincerely,

Christy Willis, Director

Susan McMenamin, Associate Director

DSS REGISTRATION FORM

Name: _____ GWid: _____

Local/Cell Phone: () _____ E-Mail Address: _____@gwmail.gwu.edu

Home Address: _____

Home Phone: () _____

Semester/Year entered GW: _____

Present Status:

- Full-time
- Part-time
- Consortium
- Visiting

Degree Status:

- Freshman
- Sophomore
- Junior
- Senior
- Graduate
- Non-Degree

Affiliation:

- Columbian College of Arts and Sciences
- Elliott School of International Affairs
- Graduate School of Education and Human Development
- Law School
- School of Business
- School of Engineering and Applied Science
- School of Medicine and Health Sciences
- School of Public Health and Health Services

Major Field of Study: _____

Disability Classification:

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit/Hyperactivity Dis. | <input type="checkbox"/> Learning Disorder |
| <input type="checkbox"/> Chronic Health Disorder | <input type="checkbox"/> Physical Disorder |
| <input type="checkbox"/> Cognitive Disorder | <input type="checkbox"/> Psychological Disorder |
| <input type="checkbox"/> Communication Disorder | <input type="checkbox"/> Temporary Disability |
| <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Vision Disorder |

When was your disability first diagnosed? _____

Describe the academic implications of your disability:

What accommodations are you requesting?

Are you a Vocational Rehabilitation client? ___ Yes ___ No If yes, what state? _____

Please list any medications which you are taking and how they may affect your academic work:

Please describe any additional concerns you have:

Background information:

Sex: ___ Male ___ Female

Date of Birth: _____ Age: _____

Citizen status: ___ US citizen ___ US permanent resident ___ International

What is your race/ethnic background?

- ___ African American, Black
- ___ Native American, American Indian
- ___ Asian American, Pacific Islander
- ___ Hispanic, Chicano, Latino
- ___ Caucasian, White, non-Hispanic
- ___ Other (specify) _____

AUTHORIZATION TO DISCLOSE INFORMATION

I hereby authorize Disability Support Services to disclose information about my disability to GW professors and personnel directly involved in providing academic or support services.

Additional persons authorized to receive above information:

- ___ Parent
- ___ Diagnostician
- ___ Mental Health Professional
- ___ Other _____

Comments: _____

I understand that I have a right to inspect my Disability Support Services file and that this authorization is subject to revocation.

Signature _____ Date: _____

Name: _____ Witness: _____

**DISABILITY SUPPORT SERVICES
LETTER TO PROFESSOR REQUEST FORM**

Name: _____ GWid: _____

Local Address: _____

Local/Cell
Phone: _____

Email Address: _____ @gwmil.gwu.edu (use only valid GW email)

I am requesting letters for _____ (semester) _____ (year)

_____ All classes

_____ Some classes
(please specify)

Please note:

- **DSS will email you when letters are ready for pickup.**
- **It is your responsibility to hand deliver letters to professors.**
- **DSS will only hold letters for two weeks from the date of original email notice.**

Signature _____ Date _____