

**SUSQUEHANNA UNIVERSITY**  
**DISABILITY DISCLOSURE AND REQUEST FOR ACCOMMODATIONS**

This form must be completed in order to receive accommodations. Submission of current, detailed documentation of the disability with this completed form is required in order to process the request. Return this form to the Office of Disability Services at Susquehanna University, 514 University Ave. Selinsgrove, PA 17870 or fax it to 570-372-2778.

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<b>Name (Please Print)</b>	<b>Birthdate</b>	<b>Graduation Year</b>	<b>Today's Date</b>
<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Cell Phone Number</b>	<b>Email Address</b>		
<b>Parent Name</b>	<b>Parent Phone Number</b>	<b>Parent Email Address</b>	

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Please check all that apply.

Type of Accommodation:  Academic       Housing       Dining       Other

Due to:

- |  |   |
|--|---|
| <input type="checkbox"/> ADD/ADHD                                    | <input type="checkbox"/> Blind/Low Vision/Visual Impairment |
| <input type="checkbox"/> Learning Disability                         | <input type="checkbox"/> Deaf/Hearing Impaired              |
| <input type="checkbox"/> Psychiatric/Behavioral/Mental Health        | <input type="checkbox"/> Mobility Impairment                |
| <input type="checkbox"/> Health Impairment/Chronic Medical Condition | <input type="checkbox"/> Other: _____                       |

Please specify type & degree of diagnosis/condition and what accommodations are being requested. Use back of form if additional space is needed:

*Example: Moderately severe (degree) processing speed disorder and learning disability in reading (specific type of impairment). Requesting extended time on exams and access to audiobooks (requested accommodations).*

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**CONFIDENTIALITY and RELEASE of INFORMATION**

**Permission to Release Information:**

I give my permission for the release and discussion of information regarding my disability and accommodations between the Office of Disability Services and University personnel. I understand that information shall only be shared with others within the institution on a "need-to-know basis", as required by law. This means that University personnel outside of the Office of Disability Services do not have a right or a need to access diagnostic or other information regarding my disability; they only need to know what academic adjustments, auxiliary aids, and/or services are necessary or appropriate to provide the accommodations. I may rescind or amend this agreement at any time.

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

Date: \_\_\_\_\_

**Permission to Release Information to Parent or Guardian:**

I give permission to release and discuss my accommodations and academic progress with my parent(s) or guardian(s):

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

Date: \_\_\_\_\_

*This form must be accompanied by appropriate documentation (i.e., evaluation report or Medical Provider Form).*