

Date \_\_\_\_\_

DOE \_\_\_\_\_

### APPLICATION FOR DISABILITY SERVICES

Name \_\_\_\_\_ Student ID \_\_\_\_\_

Address \_\_\_\_\_  
                    First                      Last                      Middle Initial                      City                      ST                      Zip Code \_\_\_\_\_

Phone No. (H) (\_\_\_\_) \_\_\_\_\_ (W) (\_\_\_\_) \_\_\_\_\_ E-Mail \_\_\_\_\_

Live on Campus? Yes \_\_\_\_\_ No \_\_\_\_\_ N/A \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Emergency Contact \_\_\_\_\_

Student \_\_\_\_\_ Major \_\_\_\_\_ Employee \_\_\_\_\_ Dept. \_\_\_\_\_

Classification: Freshman \_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior \_\_\_ Graduate \_\_\_ N/A \_\_\_

Explain your disability and current treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What accommodations are you requesting? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you take prescription medication? Please name it, the dosage and the physician who prescribed it.

\_\_\_\_\_  
\_\_\_\_\_

Services or any other agency? If you answered yes, please name your counselor or contact person and his/her location. \_\_\_\_\_.

Once you make application for services and provide the appropriate documentation, the Disability Services Coordinator/Director of Human Resources will review your documentation and inform you of your status as a student or employee with a disability.

## **Permission to Release Information**

I \_\_\_\_\_, hereby give my permission to Troy University to

Print Name

discuss information concerning my disability and accommodations and/or to release documentation on my disability, with individuals who will be involved in the delivery of services to me for my benefit. I also give permission for other agencies and individuals to discuss and release information to the Troy University Disability Services Coordinator. In addition, pertinent



**TROY UNIVERSITY  
ADA GRIEVANCE FORM**

**Complainant:**

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

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_

Faculty \_\_\_\_\_ Staff \_\_\_\_\_ Student \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Respondent:**

Name of person or group the complaint is against: \_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Faculty \_\_\_\_\_ Staff \_\_\_\_\_ Student \_\_\_\_\_ Other (specify) \_\_\_\_\_

What was the result of your discussion with the respondent? (Please use back if additional space is necessary)

\_\_\_\_\_  
\_\_\_\_\_

**Complaint Details:**

Date and Time: \_\_\_\_\_ Location: \_\_\_\_\_

What happened? \_\_\_\_\_

(Please use back of form if additional space is necessary)

Names and phone numbers of others who can verify what happened:

\_\_\_\_\_

What would you like to see happen (for you, for others) with respect to this issue?

\_\_\_\_\_  
\_\_\_\_\_

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**OFFICE USE ONLY**

**Actions Taken:** \_\_\_\_\_

\_\_\_\_\_