University of Arkansas at Pine Bluff
Disability Intake Form

PERSONAL INFORMATION

DATE: ________________

NAME: (Mr. Mrs. Miss) __________________________________________
Last First MI

PERMANENT MAILING ADDRESS: ____________________________________
P.O. Box or Street
CITY, STATE, ZIP, COUNTY _________________________________________
PHONE: Home ( ) ______-_______

TEMPORARY ADDRESS: ______________________________________________
P.O. Box or Street
CITY, STATE, ZIP, COUNTY _________________________________________
PHONE: ( ) ______ - ______
WORK ( ) ______ - ______

DATE OF BIRTH: ___/___/____ SOCIAL SECURITY NUMBER: _____/___/____

CAMPUS INFORMATION

DORM BLDG: ________________ DORM PHONE: ( ) ______-_______
RESIDENCE HALL DIRECTOR: _________________________________________
CLASSIFICATION: _____FRESHMAN _____SOPHOMORE _____JUNIOR _____SENIOR
MAJOR: ___________________________ MINOR: ___________________________
GPA: _______________ CUMMULATIVE GPA: ______________

EMERGENCY CONTACT: ______________________ PHONE: ( ) ______-_______

KNOWN DISABILITY:

_____________________________________________________________________

_____________________________________________________________________

Interviewer Signature ___________________________ Student Signature ___________
UNIVERSITY OF ARKANSAS AT PINE BLUFF
OFFICE OF DISABILITY SERVICES

ACCOMMODATIONS REQUEST

Date: ____________________________________________

Student: ________________________________________ ID#: __________________________

Students with disabilities are eligible for reasonable accommodations per Section 504 of the Rehabilitation Act of 1973 and the ADA of 1990. Accommodations provide equal opportunity to obtain the same level of achievement while maintaining the standards of excellence of the university. Confidential, qualifying documentation for this student is either on file in our office or being processed. Please call ext. 8512 if you have any questions. Thank you for your cooperation in responding to the needs of this student.

ACCOMMODATIONS: The instructor has the right to challenge any accommodation that would fundamentally alter the nature and standards of the course.

MODIFIED TESTING

_____ Extended time
_____ Non-distracting environment
_____ Oral exam
_____ Verbatim text reader
_____ Scribe
_____ No Scantron

Other

_____ Note taking
_____ Interpreter
_____ Extended time for assignment completion

ADAPTIVE TECHNOLOGY

_____ Computer/word processing
_____ Spell checker
_____ Calculator
_____ Tape recorder

TEMPORARY MEDICAL

_________________________________________

ADAPTIVE TECHNOLOGY

_________________________________________

TEMPORARY MEDICAL

_________________________________________

PHYSICAL ENVIRONMENT

_____ Preferential seating
_____ Alternative chair/table
_____ Opportunity to stand or move about

SPECIAL ARRANGEMENTS

_________________________________________

Student

_________________________________________

Date
UNIVERSITY OF ARKANSAS AT PINE BLUFF
Office of Disability Services
1200 North University Drive
Mail Slot 4949
Pine Bluff, AR 71601
870-575-8552
870-575-4652 (Fax)

REQUEST FOR RELEASE OF INDIVIDUAL EDUCATION PLAN

I, ______________________________________

SS# ______________________________________

Authorize ______________________________________

______________________________
Physician

______________________________
Address

To forward a copy of my Individual Education Plan to:

Mr. Michael Bumpers, Director
Office of Disability Services
University of Arkansas at Pine Bluff
Mail Slot 4949, 1200 North University Drive
Pine Bluff, AR 71601

I understand that this release expires sixty (60) days from the date, which appears below.

____________________________________
Signature of Client

____________________________________
Date
Entering Golden Lion Country:

✓ Contact the Office of Disability Services to schedule an appointment to meet with Mr. Michael Bumpers preferably 4 to 6 weeks before you register for classes, to discuss documentation requirements.

✓ Provide documentation of your disability to the Office of Disability Services. The documentation must be from a licensed physician and verify your eligibility as a person with a disability and support your need for requested academic adjustments, accommodations, or auxiliary aids. Individualized Education Plan (IEP) used in secondary education is not considered acceptable for higher education, but can be used as supporting documentation.

✓ Once a request has been approved, on a case-by-case basis, then the student will be informed of how to access the service.

✓ Students are encouraged to register during early registration. The sooner you are registered the earlier Office of Disability Services can assist and prepare your Accommodations Request Form.

✓ Request for alternative print formats (Braille, large print, audio text, text on CD), interpreters, and adaptive technology need to be made a minimum of two months before the beginning of classes in order to receive services in a timely manner. Braille materials may take as much as 6 months or longer to produce.

✓ Requests for other academic accommodations (e.g.: adapted testing, note taker assistance, tape recording lectures, laboratory assistance) should be made as needed.

✓ The student must make requests for academic adjustments or accommodations each semester.

✓ Consider asking about time management and study strategies for college students from the Office of Disability Services.
✓ Communication with the Office of Disability Services and your professors is essential in providing you with access to our educational programs.

✓ Early contact with the Office of Disability Services will provide for a smoother transition in obtaining needed services in a timely manner.

**Contact Information:**

Office of Disability Services  
1200 N. University Avenue, Mail Slot 4949  
Caldwell Hall, Suite 206  
Pine Bluff, Arkansas 71601

Michael Bumpers, Director  
870-575-8552  
bumpersm@uapb.edu
DISABILITY SERVICE GUIDELINES

Congress passes Section 504 of the Rehabilitation Act in 1973. It is a civil rights statute designed to prevent discrimination against individuals with disabilities.

No otherwise qualified individual with disabilities
In the United States…shall, solely by reason of
His/her disability, be excluded from the participation
In, be denied the benefits of, or be subjected to discrimination
under any program activities receiving federal financial assistance.

An institution of Higher Education must provide a student academic adjustments to ensure that she/he receive an equal opportunity to participate.

STUDENT ACCOUNTABILITY
The student has an obligation to self-identify that she/he has a disability and need accommodation. UAPB will require that the student provide appropriate documentation, at the student’s expense, in order to establish the existence of the disability and the need for accommodation. Documentation should be mailed to our office.

ACCOMMODATIONS
Students’ documentation should list their needs. The students ask only for accommodation stated in reports, other accommodations may be provided each semester depending on academic needs. The needs list should be mailed to our office.

SERVICES
We (UAPB) will provide reasonable accommodations to the student’s known disability in order to afford him/her equal opportunity to participate in the institution’s programs and activities.

- Substitution of non-essential courses for degree requirements
- Additional time to complete course work
- Adaptation of course instruction
Priority seating, testing and classes
Priority registration
Institutional membership with Recording for the Blind (RFB&D)
Tape recorders
Assisting in help finding note taker
Counseling Referral
Tutorial Referral
Note-takers
Readers
Taped lectures
Assistance with time management and study skills
Non-distraction environment
Taped Texts
Reduced course load
Advocacy and liaison between faculty and student
Assistive technology (calculator, word processor)
Other accommodations as deemed necessary by documentation

ADMISSIONS
Student should have his or her documentation from a clinical Psychologist, Physician, Vocational Evaluation, or etc., office records. The report should be no more than three (3) years old. All documentation should be sent to:

University of Arkansas at Pine Bluff
Office of Disability Services
1200 North University Drive
Mail Slot 4949
Pine Bluff, Arkansas 71601
UAPB OFFICE OF DISABILITY SERVICES

PHYSICAL AND SYSTEMIC (MEDICAL) DISABILITY DOCUMENTATION REQUEST FORM

THIS FORM MUST CONTAIN ALL OF THE REQUESTED INFORMATION AND BE TYPED OR PRINTED IN ORDER TO APPLY FOR ACCOMMODATIONS THROUGH THE OFFICE OF DISABILITY SERVICES.

Student’s Name: _______________________________________________________________________________________

Date of Birth: _________________________________________________________________________________________

Address: ____________________________________________________________________________________________

Phone Number: _______________________________________________________________________________________

Social Security Number: ______________________________________________________________________________

This student is requesting service, academic adjustment, and/or other accommodations from the Office of Disability Services. In order to consider this request, as well as to ensure the provision of reasonable and appropriate services, University Policy requires that a Qualified Professional provide current and comprehensive documentation. A qualified professional includes a medical doctor or other qualified healthcare professional. **IN ORDER TO BE CONSIDERED CURRENT, THE QUALIFIED PROFESSIONAL’S STATEMENT MUST BE WITHIN 3 YEARS PRIOR TO THE DATE OF THE MOST RECENT REQUEST FROM THE OFFICE OF DISABILITY SERVICES.**

The documentation provided must include information that diagnosis a physical or systemic (medical) disability, describes in an educational setting, indicates the severity and longevity of the physical or systemic (medical) disability for the purpose of determining academic adjustment(s) or other accommodation(s), and lists current medication along with any current side-effects that may impact academic performance.

If it is a visual disability, the documentation must include the student’s visual acuity (best corrected), a description of the effects of the visual problems, and a recommended font size for text when enlarged test is recommended as an accommodation.

To facilitate the gathering of such critical information, please respond to the following and return to UAPB, Office of Disability Services.

1. Diagnosis _______________________________________________________________________________________

2. Date of Diagnosis: ___________________ Date of last contact with student ___________________

If the problem associated with the condition are temporary, how long will the problems last?

______________________________________________________________________________________________
3. Describe the student’s functional limitations in an education setting: ____________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

4. List current medication along with any current side-effects that may impact academic performance:
_____________________________________________________________________________________

5. If there are flare-ups or episodes of the disorder, how often do they occur and how long do they last?
_____________________________________________________________________________________

6. How would you rate the severity on a scale of 1 (very mild) to 10 (very severe)? ________________

7. Does the disability directly affect ability to attend class regularly? If so, why and how often? ________
_____________________________________________________________________________________

8. Recommended accommodations for student disability: _________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Qualified Professional’s Signature: _________________________________________________________

Printed Name & Title: ___________________________________________________________________

Daytime Telephone Number: _______________________________________________________________

Address: ______________________________________________________________________________

Date: ________________________________________________________________________________

Please return this form to: Office of Disability Services
University of Arkansas at Pine Bluff
1200 North University Drive
Mail Slot 4949
Pine Bluff, Arkansas
Phone: 870-575-8552 or 870-575-8512
Fax: 870-575-4652
This individual has self-disclosed the following disability or disabilities:
_____________________________________________________________________________________

In order to provide appropriate accommodations designed to give the student equal access in the university setting, we need to know how the disability impacts functioning in this setting.

**DSM IV Name and Diagnostic Code**

Axis I: ___________________________________________  Axis IV: ___________________________________________
Axis II: ___________________________________________  Axis V: ___________________________________________
Axis III: ___________________________________________  Date diagnosed: __________ last visit: __________

1. Please check which of the following, if any, are affected significantly enough to have a negative impact in a higher education setting.

   ____ Expression – oral  ____ Reception – auditory  ____ Perceptual distortions
   ____ Concentration  ____ Expression – written  ____ Reception - written
   ____ Delusions  ____ Working in group’s  ____ Time management/organization

Please explain further if perceptual distortions or delusions occur:
_____________________________________________________________________________________
_____________________________________________________________________________________

2. Does the disability significantly directly affect ability to attend class regularly? If so, why?
_____________________________________________________________________________________

3. Does the disability cause a threat to safety of self or others? If so, in what way?
_____________________________________________________________________________________

4. What medications does this individual take regularly, and what side effects do these have that might significantly impact education?
_____________________________________________________________________________________
_____________________________________________________________________________________

5. If the diagnosis includes a phobic response to exams, is it to such an extent that the student would not be able to demonstrate knowledge on an exam administered normally? _____ Yes _____ No ______

6. Please rate severity of the disability on a scale of 1 (very mild) to 10 (very severe)? __________

7. Is the condition chronic? _____ Yes _____ No if no, expected recovery time: __________

Please attach your diagnostic report, including test scores, and other relevant information.

Signature of diagnosing professional: ___________________________ Date: __________
Professional license and number: ___________________________