University of Arkansas at Pine Bluff
Disability Intake Form

PERSONAL INFORMATION

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: ___/___/____    STUDENT ID 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 __________
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. 8089 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.

<table>
<thead>
<tr>
<th>MODIFIED TESTING</th>
<th>Other</th>
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<tr>
<td>_____ Extended time</td>
<td>_____ Note taking</td>
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<tr>
<td>_____ Non-distracting environment</td>
<td>_____ Interpreter</td>
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<tr>
<td>_____ Oral exam</td>
<td>_____ Extended time for assignment completion</td>
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<td>_____ Verbatim text reader</td>
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<td>_____ Scribe</td>
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<td>_____ No Scantron</td>
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<tr>
<th>ADAPTIVE TECHNOLOGY</th>
<th>TEMPORARY MEDICAL</th>
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<tbody>
<tr>
<td>_____ Computer/word processing</td>
<td>_________________________________</td>
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<tr>
<td>_____ Spell checker</td>
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<tr>
<td>_____ Calculator</td>
<td></td>
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<td>_____ Tape recorder</td>
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<tr>
<th>PHYSICAL ENVIRONMENT</th>
<th>SPECIAL ARRANGEMENTS</th>
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<tr>
<td>_____ Preferential seating</td>
<td>_________________________________</td>
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<tr>
<td>_____ Alternative chair/table</td>
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<tr>
<td>_____ Opportunity to stand or move about</td>
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__________________________________  ________________________________
Student                                    Date
REQUEST FOR RELEASE OF INDIVIDUAL EDUCATION PLAN

I, ______________________________________

ID# ______________________________________

Authorize _______________________________________________________________________

_________________________  ____________________________
Physician                      Address

To forward a copy of my Individual Education Plan to:

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

✓ 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:

Disability Services Office
1200 N. University Avenue, Mail Slot 4949
Caldwell Hall, Suite 208
Pine Bluff, Arkansas 71601

Michael Bumpers, Director
870-575-8089
bumpersm@uapb.edu
DISABILITY SERVICE GUIDELINES

Congress passes Section 504 of the Rehabilitation Act in 1973. It is a civil rights statue 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 inn 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
- Assistance with time management and study skills
- Non-distraction environment
- 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
Disability Services Office
1200 North University Drive
Mail Slot 4949
Pine Bluff, Arkansas 71601
UAPB DISABILITY SERVICES OFFICE

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 Disability Services Office. 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 text is recommended as an accommodation.

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

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:
University of Arkansas at Pine Bluff
Disability Services Office
1200 North University Drive
Mail Slot 4949
Pine Bluff, Arkansas
Phone: 870-575-8089 or 870-575-8552
Fax: 870-575-4618
PSYCHOLOGICAL DISABILITIES – FUNCTIONAL LIMITATIONS FORM
UNIVERSITY OF ARKANSAS AT PINE BLUFF
DISABILITY SERVICES

Name: __________________________ ID#: ___________________ DOB: ____________

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: ______________________________________________________