

COLUMBIA UNIVERSITY DISABILITY IDENTIFICATION FORM

(Submission is optional; however, if services are requested this form must be completed.)

NAME: _____ DATE: _____

SS#: _____ - _____ - _____ SEX: _____ AGE: _____ BIRTHDATE: _____

STATUS: ___FACULTY ___STAFF ___STUDENT (indicate student status below)
 ___PROSPECTIVE ___GRADUATE
 ___UNDERGRADUTE ___OTHER
 Year: Fr__ So__ Jr__ Sr__

School: _____ Campus: ___Morningside
 Major: _____ ___Health Sciences
 Expected Graduation Date: _____ ___Other (Specify: _____)

CAMPUS ADDRESS: _____
 Street address City State Zip

HOME ADDRESS: _____
 Street address City State Zip

TELEPHONE: (CAMPUS) _____ (HOME) _____

EMAIL: _____ FAX: _____

RESIDENCE: ___UNIVERSITY RESIDENCE HALL ___OFF-CAMPUS (walking distance)
 ___UNIVERSITY APARTMENT ___OFF-CAMPUS (commuter)

DISABILITY INFORMATION: ___PERMANENT ___TEMPORARY (Duration: _____)

Disability Documentation

- Disability documentation must be on clinician's letterhead and include diagnosis, nature of disabling condition, limitations, any recommended accommodations and duration, if temporary.
- Specific guidelines for submission of documentation of learning disabilities and attention deficit disorders are available from the Office.
- Comprehensiveness and currency of disability documentation is essential to enable the Director to assess the appropriateness and necessity for accommodations consistent with disability needs, academic standards, and curricular requirements.
- No request for accommodation will be considered without sufficient documentation and signed release giving the Director permission to speak to clinician. Release forms are available from the office.
- **Documentation** should be submitted to: Director
 University Office of Disability Services
 Lerner Hall, Suite 802
 2920 Broadway, MC 2605
 Columbia University
 New York, NY 10027 or Fax to: (212) 854-3448

NATURE OF DISABILITY: (CHECK ALL THAT APPLY)

- | | |
|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> PSYCHIATRIC |
| <input type="checkbox"/> CHRONIC MEDICAL CONDITION | <input type="checkbox"/> SPEECH |
| <input type="checkbox"/> EATING DISORDER | <input type="checkbox"/> SUBSTANCE ABUSE |
| <input type="checkbox"/> HEARING | <input type="checkbox"/> TRAUMATIC BRAIN INJURY |
| <input type="checkbox"/> LEARNING | <input type="checkbox"/> VISUAL |
| <input type="checkbox"/> MOBILITY | <input type="checkbox"/> OTHER (Specify) _____ |
| <input type="checkbox"/> Uses Braces, Crutches, or Canes | |
| <input type="checkbox"/> Uses Wheelchair (<input type="checkbox"/> Electric or <input type="checkbox"/> Manual) | |

BRIEFLY DESCRIBE YOUR DISABILITY: (Supporting Medical Documentation is required):

Are you affiliated with your State Department of Vocational Education? YES NO

Do you need accommodations in order to perform your coursework? YES NO

If YES, please check all that apply:

- | | | |
|--|--|---|
| <input type="checkbox"/> Accessibility information | <input type="checkbox"/> Dining services | <input type="checkbox"/> Sign language interpreters |
| <input type="checkbox"/> Admissions information | <input type="checkbox"/> Disability information | <input type="checkbox"/> Taped texts |
| <input type="checkbox"/> Bookstore assistance | <input type="checkbox"/> Employment accommodations | <input type="checkbox"/> Tape recorder |
| <input type="checkbox"/> Classroom scheduling | <input type="checkbox"/> Equipment | <input type="checkbox"/> Testing accommodations |
| <input type="checkbox"/> Computing assistance | <input type="checkbox"/> Leave accommodations | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Libraries | <input type="checkbox"/> Parking | <input type="checkbox"/> Other(Specify) |
| <input type="checkbox"/> Note-taking assistance | <input type="checkbox"/> Readers | |
| <input type="checkbox"/> Mobility instructor | <input type="checkbox"/> Resource/referral info. | |

Please briefly describe the accommodation you think you will need, allow at least 8 weeks' notice (14 weeks for taped texts or special housing arrangements) before the start of the semester involved:

IN CASE OF EMERGENCY CONTACT:

NAME: _____

ADDRESS: _____
Street address City State Zip

TELEPHONE: _____ RELATIONSHIP: _____

Please return this form to the University Office of Disability Services, Lerner Hall, Suite 802, 2820 Broadway, MC 2605, Columbia University, New York, NY 10027. If you have any questions, please contact the Office: Voice (212) 854-2388, TDD (212) 854-2378, E-mail disability@columbia.edu.

(Office use only)		Nature of contact: Phone <input type="checkbox"/> Mail <input type="checkbox"/> In person <input type="checkbox"/>	
DS staff contact: _____		School Disability Liaison Officer: _____	
ACTION TAKEN: _____		Date: _____	
Comments: _____		Rev 2/01	