South Dakota School of Mines and Technology
Disability Services

Request for Section 504 ADA Services

Please provide all information requested in order to enable the university to best meet your needs. If you need help completing this form, please phone Disability Coordinator Amanda Lopez at 394-2533. This form is available in taped and large print formats by request.

Date: _________________

Name: ___________________________ Preferred name: ___________________________

DOB: _________________

Current Address: ____________________________________________________________

Phone: __________________________ E-mail: ________________________________

Please check each item that applies:

_____ Applying for Admission Accepted for Next Semester

_____ Freshman

_____ Sophomore

_____ Junior

_____ Senior

_____ Graduate

_____ Other (please specify) Major: ___________________ Referred by: ___________________________

Please list the names, addresses and phone numbers of each of your current physicians, therapists, counselors or other support services providers below. Indicate the person’s role (e.g. Mary Smith, speech therapist, 123 East 4th St, Rapid City 555-6789)

Do you receive assistance from Vocational Rehabilitation or Services for Visually Impaired?

_____ yes _____ no

If yes, please indicate the name, address and phone number of your VRISVI Counselor.
Disability type: (please check all that apply)

_____Hearing           _____Neurological Condition
_____Speech            _____Respiratory Condition
_____Vision            _____Attention Deficit
_____Mobility          _____Psychological/Psychiatric Condition
_____Learning Disability
_____other (please describe):____________________________________

How does your disability impact your ability to function in an academic setting? Please be as specific as possible.

Are you currently taking medication? _____yes _____no
If yes, please specify which medications and possible side effects.

Did you receive support or special services for disabilities while in high school? _____yes _____no
If yes, please describe.

If possible, please attach or have a copy of your most recent Individualized Education Plan sent to:

SDSM&T
Attention: Amanda Lopez, Title IX and Disability Coordinator
Surbeck Center
501 East Saint Joseph Street
Rapid City, SD 57701
Fax: 605-394-2721
Please check all adaptive equipment you use on a regular basis:

_____ cane  _____ hand splints
_____ lap board  _____ lift-equipped van
_____ headpointer  _____ assistive speech device
_____ transfer equipment  _____ tape recorder
_____ laptop computer  _____ talking equipment
_____ magnification equipment  _____ power wheelchair
_____ speech transmission device  _____ manual wheelchair
_____ crutches  _____ communication board
_____ other (specify)

Where will/do you reside during the school semester?

___ on-campus
___ own home/apartment
___ shared apartment/house with friends
___ with family fraternity/sorority house

Will you require assistance for personal needs on campus? ____ yes ______ no

If yes, please describe:


Have you been or are you frequently absent from school as a result of medical problems?

____ yes ____ no

If yes, please describe:

Check all of the services you think you may need. Please note: Not all adaptations may be available at SDSM&T at this time.

_____ extended test time
_____ interpreter
_____ accessible classrooms
_____ alternate testing procedures
_____ special parking permit
_____ wheelchair storage
_____ accessible residence hall accommodations
_____ taped textbooks
ALL STUDENTS ARE REQUIRED TO PROVIDE MEDICAL OR OTHER APPROPRIATE DIAGNOSTIC EVALUATION OF THEIR DISABILITY.

Disability Documentation provided should include, but may not be limited to the following:

- Demonstration of comprehensive assessments and evaluations, using adult scales, conducted by an appropriately credentialed professional;
- Demonstration of the evaluator having ruled out alternative explanations and diagnoses for presenting problems;
- Clear statement of the current impact of the disability upon major life functions and the functional limitations in an educational environment;
- Background information – pertinent and relevant histories – academic, family, developmental, medical, psychosocial, treatment, therapy, interventions and accommodations
- Specific diagnosis with accommodations recommendations; and
- Signature and contact information of diagnostician including mailing address, telephone number and e-mail address.

Statement of Agreement:

I understand that the staff from the Office of Academic Services may have access to my file in the Disability Services Office, as well as academic and other University records in order to provide me with the support services I need. I further understand that in order to meet my educational needs, it may be necessary for the Disability Office to contact my faculty or other campus offices and disclose information about my disability and needs. I understand that it is my responsibility to notify the Disability Office of any change in my medical status or special needs. By completing this form, I consent to such disclosures by the Disability Office, except that I do not want the following persons/offices to receive personal information about my disability:

_____________________________________________________________________________

Signed                                      Date
Statement of Consent to Share Information:

I **give** Disability Services at the South Dakota School of Mines and Technology permission to share information with the following. **THIS CONSENT IS NOT FERPA! GRADES WILL NOT BE DISCUSSED.**

(Please circle all that apply)

- Parents
- Spouse
- Therapist
- Physician
- Legal Guardians
- Professor
- Counselor
- Vocational Rehabilitation
- Dean of Students
- Other: ________________

I **do not** give Disability Services permission to share information with the following:

________________________________________________________________________

________________________________________________________________________

Signed:_____________________________  Date:________________________

Comments:________________________________________________________________

Please return this form with appropriate documents to:

Disability Services Office
Attention Amanda Lopez, Title IX and Disability Coordinator
Surbeck Center
501 East Saint Joseph Street
Rapid City, SD 57701

You may also email amanda.lopez@sdsmt.edu or fax to 605-394-2721