

## STUDENT REQUEST FOR DISABILITY SERVICES

This form is to be completed by the STUDENT. If assistance is needed, please ask the Disability Case Manager  
Fill out the form as completely as possible prior to meeting with the Disability Case Manager

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

Name: \_\_\_\_\_ Banner ID# 900 \_\_\_\_\_

Email: \_\_\_\_\_@student.nmt.edu Contact #: \_\_\_\_\_

DOB: \_\_\_\_\_ Campus PO Box #: \_\_\_\_\_

Campus Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home address (if different than above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**By providing an emergency contact you give New Mexico Tech permission to contact this person in an emergency.**

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Email: \_\_\_\_\_ Contact #: \_\_\_\_\_

### SCHOOL DATA:

Year in School:     Freshman         Sophomore         Junior         Senior         Graduate

Student Status:     Full-time         Part-time         Prospective

Is this your first semester at Tech?     YES         NO

If not, date of first semester at Tech: \_\_\_\_\_

Are you a transfer student?     YES         NO

Major area of study: \_\_\_\_\_ Advisor: \_\_\_\_\_

Current GPA: \_\_\_\_\_

How are your grades this semester:     Excellent         Good         Fair         Poor

Has your academic performance changed?  YES         NO

*Focused education in science and engineering*



If yes, how? \_\_\_\_\_  
\_\_\_\_\_

Do you have a Tech scholarship or the New Mexico Lottery Scholarship:       YES       NO

If yes, please list: \_\_\_\_\_

**EMPLOYMENT DATA:**

Are you working? :       YES       NO

Place of employment: \_\_\_\_\_ Hours per week: \_\_\_\_\_

**DISABILITY INFORMATION:**

Diagnosis or type of disability: \_\_\_\_\_

Date you were diagnosed: \_\_\_\_\_ Date of most recent diagnosis: \_\_\_\_\_

Name of Diagnostician: \_\_\_\_\_

Medications currently prescribed for your disability, please list:

1) \_\_\_\_\_ 2) \_\_\_\_\_  
3) \_\_\_\_\_ 4) \_\_\_\_\_

Do you currently have a primary care provider for your disability?:       YES       NO

Name and Profession: \_\_\_\_\_

Physical Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email: \_\_\_\_\_ Contact #: \_\_\_\_\_

Check the major life activities/major bodily function your disability currently “substantially limits” Include, but are not limited to:

- |                                          |                                                  |                                      |
|------------------------------------------|--------------------------------------------------|--------------------------------------|
| <input type="checkbox"/> Bending         | <input type="checkbox"/> Endocrine               | <input type="checkbox"/> Respiratory |
| <input type="checkbox"/> Bladder         | <input type="checkbox"/> Hearing                 | <input type="checkbox"/> Seeing      |
| <input type="checkbox"/> Bowel           | <input type="checkbox"/> Immune System           | <input type="checkbox"/> Sleeping    |
| <input type="checkbox"/> Brain           | <input type="checkbox"/> Interacting with others | <input type="checkbox"/> Speaking    |
| <input type="checkbox"/> Breathing       | <input type="checkbox"/> Learning                | <input type="checkbox"/> Standing    |
| <input type="checkbox"/> Caring for self | <input type="checkbox"/> Lifting                 | <input type="checkbox"/> Thinking    |
| <input type="checkbox"/> Circulatory     | <input type="checkbox"/> Neurological            | <input type="checkbox"/> Walking     |
| <input type="checkbox"/> Communicating   | <input type="checkbox"/> Normal cell growth      | <input type="checkbox"/> Working     |
| <input type="checkbox"/> Concentrating   | <input type="checkbox"/> Performing manual tasks |                                      |
| <input type="checkbox"/> Digestive       | <input type="checkbox"/> Reading                 |                                      |
| <input type="checkbox"/> Eating          | <input type="checkbox"/> Reproductive functions  |                                      |
| <input type="checkbox"/> Other _____     |                                                  |                                      |

How does your disability limit your academic performance?

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Please describe the issues that you are experiencing in class/housing/other setting that require accommodations:

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Have you received accommodations for your disability in the past:       YES       NO

Where and what accommodation/s (list previous institutions and accommodation/s):

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Check any of the following outside agencies from which you have received support:

- |                                                                    |                                                    |
|--------------------------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> CMC-Randolph                              | <input type="checkbox"/> VA                        |
| <input type="checkbox"/> Services for the Blind                    | <input type="checkbox"/> Vocational Rehabilitation |
| <input type="checkbox"/> Services for the Deaf and Hard of Hearing | <input type="checkbox"/> Other: _____              |

What services did this agency provide? \_\_\_\_\_

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Which of the following tasks do you HAVE DIFFICULTY doing? (check all that apply)

- |                                                  |                                                      |                                          |
|--------------------------------------------------|------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Communication           | <input type="checkbox"/> Paying Attention            | <input type="checkbox"/> Taking notes    |
| <input type="checkbox"/> Finishing Tests on time | <input type="checkbox"/> Putting Thoughts into words | <input type="checkbox"/> Time Management |
| <input type="checkbox"/> Following directions    | <input type="checkbox"/> Physical Activities         | <input type="checkbox"/> Writing         |
| <input type="checkbox"/> Math calculations       | <input type="checkbox"/> Reading/Understanding       |                                          |
| <input type="checkbox"/> Memorizing              | <input type="checkbox"/> Spelling                    |                                          |

**ACCOMMODATION REQUESTS**

Please describe the reasonable accommodations you are requesting: \_\_\_\_\_

\_\_\_\_\_

Any other concerns that you would like to discuss: \_\_\_\_\_

\_\_\_\_\_

**NOTE: Accommodations are approved based on the supporting documentation provided, an intake interview with a case manager and may include decisions by the Office for Disability Services team.**



## NMT Student Agreement for Disability Services and Accommodations

My signature below affirms that I am registering with New Mexico Tech’s Office for Disability Services (ODS) as a student with a disability, as defined by the Americans with Disabilities Act and Section 504.

I understand that despite my disability (Please initial each):

\_\_\_\_\_ I fully understand that this request for accommodation(s) is based on New Mexico Tech’s need for documentation to support my request for services.

\_\_\_\_\_ I understand that once this request for accommodation(s) is processed, I may be required to provide additional documentation, on a case-by-case basis, of changes in my condition. I understand NMT may not be able to provide services until appropriate documentation has been received.

\_\_\_\_\_ I agree to allow the disclosure of my agreed upon accommodations to my professors. I am aware that it is my responsibility to deliver and discuss my accommodation letters with each professor. I understand that choosing not to utilize accommodations is my choice, but they may not be used retroactively.

\_\_\_\_\_ I understand that ODS may have student workers assisting with filing of records. I understand my information may be shared with those within the University who have a legitimate educational interest.

\_\_\_\_\_ I must meet the academic standards as set forth by my program of study and the classes I take, with or without accommodations.

\_\_\_\_\_ I am responsible for following the Universities’ policies and the New Mexico Tech Student Handbook: A Guide to University Citizenship.

\_\_\_\_\_ I am responsible for contacting ODS each semester to review my accommodation(s).

\_\_\_\_\_ I understand that most contact with the Office for Disability Services will go through my student email account at New Mexico Tech.

\_\_\_\_\_ If I desire to have any information disclosed with outside parties, including my parents; I will sign a release of information form with ODS.

\_\_\_\_\_ I understand that student or faculty questions about accommodations should be submitted to ODS.

I, the undersigned, authorize the staff providing disability accommodation services to contact relevant New Mexico Tech student services staff, faculty or administration to share information pertaining to my accommodation(s) for the purpose of coordinating appropriate services and determining any necessary and reasonable academic accommodations.

Student Signature \_\_\_\_\_ Date: \_\_\_\_\_

NMT ODS Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The institution will provide accommodations to students with disabilities to enable students to meet institutional standards without compromising the Academic Integrity of the course, program, assignment or activity.