BethelUniversity

Office of Disability Services
Vera Low Center for Student Enrichment
325 Cherry Ave., McKenzie, TN 38201
(o) 731-352-6406 | (f) 731-352- 4208 | gibsonw@bethelu.edu

Self-Inform Questionnaire

This form must be completed for a student to register with Disability Services and request academic accommodations. Please provide complete, candid and realistic information concerning the nature of your disability, special needs, and any support services needed for you to successfully begin and/or continue your studies at Bethel University. This form is considered confidential and will be retained as such. Information provided on this form has no bearing on admission determination.

NAME: ______________________________ DATE: ______________

HOME ADDRESS: ____
Street City/State Zip County

DATE OF BIRTH: __________ PHONE: ____________ EMAIL: ____________

CAMPUS ADDRESS: ____________________ CAMPUS/OTHER PHONE: __________

STUDENT CLASSIFICATION (check all that apply):

☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate ☐ Re-Admit ☐ Transfer ☐ Other*

*If you selected Other, please explain: ______________________________

Intended Major: ____________________ Advisor: ____________________

NATURE OF DISABILITY (check all that apply):

☐ Attention Deficit Hyperactive Disorder ☐ Hearing Impairment ☐ Learning Disability
☐ Medical Disability ☐ Mobility/Orthopedic Impairment ☐ Psychological/Psychiatric
☐ Speech/Language Impairment ☐ Traumatic Brain Injury ☐ Visual Impairment

MEDICAL DIAGNOSIS OF YOUR DISABILITY: ______________________________

DATE OF ONSET OF DISABILITY and/or DIAGNOSIS: ______________________

MEDICATIONS: ____

ACCOMMODATIONS REQUIRED (check all that apply):

☐ Accessible Parking ☐ Adaptive Equipment ☐ Crutches
☐ Interpreter ☐ Personal Attendant ☐ Prosthesis
☐ Walker ☐ Wheelchair** ☐ Other*

*If you selected Other, please explain: ______________________________

**If you selected Wheelchair, please specify either manual or motorized: ______________

Bethel University Office of Disability Services - Self-Inform Questionnaire
(continued)

SUPPORT SERVICES (check all that apply):

Select all agencies you are currently receiving services from:

☐ Department of Vocational Rehabilitation Services

State: ______ County: ____________________ Counselor: __________________________ Phone: ______________

☐ Veteran's Administration

State: ______ County: ____________________ Counselor: __________________________ Phone: ______________

☐ Other: ____

State: ______ County: ____________________ Counselor: __________________________ Phone: ______________

☐ Other: ____

State: ______ County: ____________________ Counselor: __________________________ Phone: ______________

Please list any academic accommodations and/or support services that you have previously received:

____

SUMMARY

Please explain how your disability impacts your performance in the classroom: ______________________________

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Information shared with the Disability Services Office is kept confidential unless you authorize release and exchange of specified information. Completion of this form does not guarantee academic accommodations and it is your responsibility to schedule a meeting with our office to discuss the services and/or academic accommodations available as soon as you arrive on campus. **You MUST provide professional documentation to support your disability in order to qualify for academic accommodations**. Accommodations can be provided only after these conditions are met and will not be retroactive. This form is completed in consultation with the staff of the Disability Services Office.

YOUR SIGNATURE: ____ DATE: ________________________

PERSON COMPLETING THE FORM IF OTHER THAN YOURSELF:

PRINT NAME: ____ RELATIONSHIP: ________________________

(Revised 5/2019)