CUA

The Catholic University of America
Office of Disability Support Services
620 Michigan Ave NE, 201 Pryzbyla Center
Washington, DC 20064
Phone 202-319-5211, Fax 202-319-5126

Dear Prospective Student,

In order to establish eligibility for services and to enable our staff to work more effectively with you in the provision of services, please complete the enclosed Intake form and provide documentation of the disability as outlined by our Documentation Guidelines. All records will remain strictly confidential and are not a part of your academic record.

The aforementioned guidelines are provided so that Disability Support Services can respond appropriately to the individual needs of the student. We reserve the right to determine eligibility for services and modifications to programs based on the quality of the submitted documentation. All documentation is confidential.

CONFIDENTIALITY

The University recognizes that student disability records contain confidential information and are to be treated as such. Therefore, documentation of a student's disability is maintained in a confidential file in DSS and is considered part of the student's education record. Information related to a disability may be disclosed only with the permission of the student or as permitted by the university's student records policy and federal law. At the same time, however, a students' right to privacy must still be balanced against the university's need to know the information in order to provide requested and recommended services and accommodations. Therefore, in the interest of serving the needs of the student, the provision of services may involve DSS staff disclosing disability information provided by the student to appropriate University personnel participating in the accommodation process. The amount of information that may be released is determined on a case-by-case basis, and will be made in accordance with the university's policy on student records.

I have read and understand the above policies and agree with the terms. Sign your name indicating you composed and wrote the responses to the questions in the form.

Signature: _____

Name (Print): _____ Date: _____

All forms must be returned directly to:

Disability Support Services
The Catholic University of America
620 Michigan Ave NE, 201 Pryzbyla center
Washington, DC 20064
Phone: 202-319-5211 Fax: 202-319-5126
Email: cua-disabilityservices@cua.edu

IT IS STRONGLY RECOMMENDED THAT ALL FORMS AND DOCUMENTATION BE RETURNED BEFORE THE START OF THE SEMESTER IN ORDER TO ALLOW TIME FOR PROCESSING.

OFFICE USE ONLY

_____ Date Registration Form Received _____ Date Intake Completed _____ By (INT)

_____ Date Documentation Received _____ Date Additional Documentation Received

_____ Date Documentation Approved Updated: 4/11/13

DISABILITY SUPPORT SERVICES
TEMPORARY SERVICES REGISTRATION FORM

In order to receive accommodations, please submit a copy of your documentation regarding your disability with this form. Documentation guidelines are available at http://dss.cua.edu. Documentation must be received before your registration is complete.

Date: _____

I BIOGRAPHICAL INFORMATION

Name: _____
First *Middle* *Last*

Student ID # _____ Birth Date: _____ Gender: MALE FEMALE

Race/Ethnic Background (Optional): _____

Cell Phone: _____ Home Phone: _____

Other Phone: _____ Circle one: Parent's home Mom/Dad Cell

Address:

_____

_____
City *State* *Zip Code*

CUA E-mail Address: _____@cardinalmail.cua.edu

Alternate E-mail Address: _____

II STUDENT STATUS

First Semester at CUA: Fall Spring Summer Year: _____

Anticipated Date of Graduation: Fall Spring Year: _____

___ **Undergraduate Year**: ___ Freshman ___Sophomore ___ Junior ___ Senior

School/Program:

___ Arts & Sciences: Major: _____ or Exploratory (Circle)

___ Architecture ___ Music ___ Theology ___ Business & Economics

___ Engineering ___ NCSSS ___ Philosophy ___ Library & Information Sciences ___ Nursing ___ Metropolitan College of Professional Studies

CUA Athletic Sport (if applicable):

___ Baseball ___ Basketball ___ Cheerleading ___ Cross Country ___ Field Hockey

___ Football ___ Lacrosse ___ Soccer ___ Softball ___ Swimming

___ Tennis ___ Track & Field ___ Volleyball

III DISABILITY INFORMATION

____ Health/Medical Type: _____

____ Physical* Type: _____

____ Traumatic/Acquired Brain Injury/Concussion*

____ Other: _____

Please describe the cause of your injury:

_____

_____

_____

_____

Date of injury: _____ Duration: _____

Date of follow-up doctor visit: _____

If physical:

Level of Mobility:

Arm/Hand

- Dexterity: ___ All ___ None ___ Limited
- Which hand: ___ Left ___ Right ___ Both
- Which hand do you write with: ___ Left ___ Right

Leg/Foot

- Ambulatory: ___Yes ___ No ___ With minimal assistance
- Which Leg/Foot: ___Left ___ Right ___ Both
- Mobility Device Requirements:

  ___ Electric Wheelchair ___ Manual Wheelchair ___ Scooter

  ___ Other (Walker, crutches, cane, etc.)

If Traumatic/Acquired Brain Injury/Concussion:

- Was this your first head trauma: ___ Yes ___ No
- If no, how many have you had prior to now: ___ 1 ___2 ___3 ___4
- Have you seen a neurologist: ___ Yes ___ No

Please list any related medications you are taking:

Name: _____Purpose: _____Start date: _____Dosage: _____

Name: _____Purpose: _____Start date: _____Dosage: _____

Please explain how the medication helps you:

_____

_____

_____

IV CURRENT IMPACT

Functional Limitations: Please check off the activities listed below that you believe are affected as a result of your diagnosis. Please indicate level of limitation you experience as a result of the disability.

1= Unable to Determine 2= No Impact 3= Mild Impact 4= Moderate Impact 5= Substantial Impact

1	2	3	4	5	**Major Life Activities**		1	2	3	4	5	**Learning / Time Management**
					Caring for Oneself							Memory
					Talking							Concentrating
					Hearing							Listening
					Breathing							Organization
					Seeing							Managing distractions
					Walking							Timely submission of assignments
					Standing							Attending class regularly
					Lifting/Carrying							Making and keeping appointments
					Sitting							Managing stress
					Performing Manual tasks							Reading
					Eating							Writing
					Working							Spelling
					Interacting with others							Quantitative reasoning (math)
					Sleeping							Processing Speed

Describe in as much detail as possible how the diagnosed condition is currently impacting you (use additional paper if necessary).

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Accommodations/Services:

Describe accommodations or services that you think you will need. Why?

In Class Accommodations:

_____

_____

_____

_____

_____

Test Accommodations:

_____

_____

_____

_____

_____

SERVICES RECEIVED/REQUESTING: (Skip if this section does not apply to you)

	Requesting at CUA
Campus Access	
I cannot walk long distances quickly	
I cannot walk long distances at all	
I cannot go up or down stairs and need access to an elevator	
I use an assistive walking device that makes it difficult to get around independently during inclement weather	
I use crutches	
I use a cane	
I use a wheelchair	
Dining Services	
Assistance Needed (access to food choices help with tray, cutting food, eating)	
My medical condition requires me to be on a special diet	
Other	
Housing Services	
Single Room (for medical issues)	
Accessible Room (elevator, space for chair, equipment, lowered shelves, rods, grab bars, lower peep hole, visual door bell, door handles, etc.)	
Bathroom Modifications (grab bars, roll in, Bathtub, lowered sink)	
Private bath	
Access to a Kitchen for dietary/health reasons (that cannot be accommodated by consulting with the campus dietician)	
First Floor Room	
Emergency Evacuation	
Assistance may be required to evacuate a building	
Transportation	
I am driving and need access to handicap parking close to my classes	
Independent use of the Metro	
Para-Transit/Metro Access	

OPTIONAL:

If there are additional questions pertaining to my documentation, I give DSS the right to contact the professional who comp
the evaluation to obtain further information so that we can appropriately determine eligibility of services.

_____ _____ _____

Signature **Printed Name** **Date**