

Office of Disability Services

The Union 065, Box 2815

South Dakota State University

Brookings, SD 57007

Phone: 605-688-4504

Fax: 605-688-4987

Office of Disability Services: Application for Services

Date of Application: \_\_\_\_/\_\_\_\_/\_\_\_\_ Semester/Year You Will Begin Classes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Appropriate Documentation of your disability MUST be received by ODS to qualify for services. Documentation guidelines can be found at: [www.sdstate.edu/disability-services](http://www.sdstate.edu/disability-services).

Disability:

\_\_\_ Cognitive (L.D., TBI)

\_\_\_ ADD/ADHD

\_\_\_ Visual

\_\_\_ Hearing: Deaf/HH (Please Specify Language Preferences)

\_\_\_ Physical/Mobility

\_\_\_ Mental/Emotional

\_\_\_ Medical

\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RETURN TO: Office of Disability services, Box 2815, Student Union 065, SDSU, Brookings, SD 57007. Or fax to 605.688.4987**

**South Dakota State University Office of Disability Services**

**Authorization for Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Address)

hereby authorize the Coordinator of Disability Services to release information concerning my disability to any individual directly related to my academic life during my enrollment at South Dakota State university.

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