

Form A

AUTHORIZATION FOR RELEASE OF INFORMATION BY LICENSED PHYSICIAN OR PROFESSIONAL

To: _____ (Doctor, etc.)
_____ (Street Address)
_____ (City, State, Zip Code)
Day Time Phone _____ Evening Time Phone _____

I, the undersigned student, am requesting special services from Flint Hills Technical College and hereby request and authorize you to release any information pertaining to my disability.

Student's Name: _____
Date of Birth _____ Soc. Sec. No. _____
Signature of Student _____ Date _____

DISABILITY VERIFICATION

In order to provide the student with special educational services designed to help him/her be more successful in college, we require a verification of the student's disability. Please provide the following information:

1. Diagnosis _____

2. Functional limitation(s) resulting from the condition/disorder that would, in your opinion, impede the student's educational performance. Please check all that apply.

- _____ Poor concentration, distractibility and/or confusion.
- _____ Intense anxiety, phobia, and/or panic.
- _____ Difficulty completing assignments due to pressures.
- _____ Difficulty in taking notes, reading college texts, taking tests, and/or managing time.
- _____ Problems in hearing and/or speaking in class during discussions.
- _____ Other _____

3. Signature of Professional: _____
Title: _____
Date: _____

After a qualified professional has completed the Disability Verification section, please send this form to the Dean of Student Services, Flint Hills Technical College, 3301 W. 18th Ave., Emporia, KS 66801

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