

### CONFIDENTIAL DOCUMENT

To: Dean of Enrollment Management  
Flint Hills Technical College

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
City State Zip

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

### IDENTIFY NATURE OF REQUIRED SERVICE OR ACCOMMODATION

Testing accommodation, if requested in a timely manner:

Academic support services:

Auxiliary aids:

Other:

I understand that I must provide medical or other diagnostic documentation of my disability and limitations, prepared by a qualified physician, psychologist, or professional, to the Dean of Management.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
By checking this box you have created an electronic signature as legally binding as your hand-written signature. mm/dd/yyyy

IT IS THE RESPONSIBILITY OF THE INDIVIDUAL STUDENT TO REQUEST ACCOMMODATION OR AUXILIARY AIDS AT LEAST SIX (6) WEEKS BEFORE CLASSES, PROGRAMS, OR ACTIVITIES BEGIN.

### AVAILABILITY OF AUXILIARY AIDS

IT IS THE STUDENT'S RESPONSIBILITY TO MAKE WRITTEN REQUEST FOR ASSISTANCE IN OBTAINING SPECIALIZED SUPPORT SERVICES FROM OTHER RESOURCES such as State Vocational Rehabilitation, Recordings for the Blind, State Services for the Blind, etc. For example, the Division of Vocational Rehabilitation (DVR) may fund such items as transportation to the institution, tuition, text books, hearing aids, and other individually prescribed devices.

620.343.4600 | 800.711.6947 | FAX: 620.343.4610

[www.fhtc.edu](http://www.fhtc.edu)

3301 WEST 18TH AVENUE | EMPORIA, KANSAS 66801

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To: Dean of Enrollment Management  
Flint Hills Technical College

Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Last First

Permanent Address: \_\_\_\_\_  
City State Zip

Local Address: \_\_\_\_\_  
City State Zip

Date: \_\_\_\_\_ Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_  
mm/dd/yyyy

Program of Study: \_\_\_\_\_

Disability is:  Temporary  Permanent

Disability Category: Description of Disability:

Vision

Mobility/Ortho

Hearing

LD

Speech

Other

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To: Dean of Enrollment Management  
Flint Hills Technical College

I hereby give the Dean of Students Services at Flint Hills Technical College, permission to share information with the following persons/agencies:

ALL AGENCIES AND/OR PERSONS WITH A LEGITIMATE EDUCATIONAL NEED TO KNOW.

(Or, check specific groups below with whom we may share information.)

All Faculty,

Specific Faculty Only (please list): \_\_\_\_\_

Academic Advisors

Other College Personnel

Previous Educational Institutions

Medical/Counseling Facilities

Recordings for the Blind

Department of Rehabilitation

Other (please list): \_\_\_\_\_

I understand that I must provide medical or other diagnostic documentation of my disability and limitations, prepared by a qualified physician, psychologist, or professional which states the parameters of my disability, to the Dean of Enrollment Management.

Name: \_\_\_\_\_  
Last First

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

Student Signature: \_\_\_\_\_  
By checking this box you have created an electronic signature as legally binding as your hand-written signature.

mm/dd/yyyy

This confidential form will be in effect from the date signed and shall remain effective during my admission to Flint Hills Technical College unless superseded by the signing of a new form.