INSTRUCTIONS FOR REQUESTING OSWD SERVICES
Office for Students with Disabilities, Gallaudet University

ALL of the following information MUST be submitted:

1. DOCUMENTATION of your disability from the appropriate professional such as; physician, learning disability diagnostician, psychologist, and/or psychiatrist.

   The documentation for eligibility should be current (within 3 years), and include a summary of assessment procedures, when the diagnosis was first reported; medical information relating to the student’s needs to meet the demands of the academic environment; and a statement on the impact of life activities on this student. Last, the documentation should be typed on the health care practitioner’s formal letterhead. (Please note: IEPs and Form 504 are not acceptable in lieu of medical documentation.)

2. A completed INTAKE FORM

3. A PERMISSION TO RELEASE AND OBTAIN INFORMATION FORM

MAIL TO:
Gallaudet University
Office of Students with Disabilities
I. King Jordan Student Academic Center Room 1220
800 Florida Avenue, NE
Washington, D.C. 20002

FAX:
(202) 651-5887

BRING TO:
I. King Jordan Student Academic Center Room 1220

QUESTIONS?
PHONE:
(202) 651-5256

VIDEOPHONE:
(202) 250-2407/(866) 971-4243

This intake form, once submitted, will be valid for one year from the date received at the Office for Students with Disabilities. This paperwork is confidential, and will not be discussed outside the OSWD at Gallaudet University.

Updated January, 2013
INTAKE FORM
Office for Students with Disabilities, Gallaudet University

DATE: ____________________________________________

STAFF NAME: ____________________________________________

REFERRED BY: ____________________________________________

STUDENT INFORMATION

NAME: ____________________________________________

MALE ___ FEMALE ___

SOCIAL SECURITY NUMBER: ____________________________

BIRTH DATE: ____________________________________________

GALLAUDET ID NUMBER: ____________________________

E-MAIL: ____________________________ PHONE: ____________________________

CAMPUS P.O. BOX: ____________________________

DORM NAME: ____________________________ VIDEOPHONE: ____________________________

PAGER/PDA ADDRESS: ____________________________

HOME ADDRESS: ____________________________

CITY/STATE: ____________________________

ZIP CODE: ____________________________

PARENT/GUARDIAN’S NAME: ____________________________

(If the student is under 21 years of age.)

CONTACT INFORMATION: ____________________________

ARE YOU A UNITED STATES CITIZEN? YES ___ NO ___

IF “NO,” WHAT IS YOUR VISA STATUS? F1 ___ J1 ___ B1 ___ B2 ___

HAVE YOU USED OSWD SERVICES BEFORE? YES ___ NO ___

Updated January, 2013
IF “YES,” WHEN? __________________________________________

HAVE YOU USED DISABILITY SUPPORT SERVICES AT ANY OTHER UNIVERSITY BEFORE?
YES _____ NO _____

EDUCATION

NAME OF HIGH SCHOOL ________________________________

CITY/STATE ________________________________

TYPE OF HIGH SCHOOL ATTENDED ________________________________

1. RESIDENTIAL _____ 2. MAINSTREAM PUBLIC _____ 3. MAINSTREAM PRIVATE _____ 4. DAY PROGRAM  5. OTHER _____

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Name of school and City/State</th>
<th>To</th>
<th>From</th>
<th>Degree</th>
<th>Major</th>
<th>GPA</th>
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Updated January, 2013
Tell us about yourself…

DEMOGRAPHIC DATA

CLASS
___ PREP
___ FRESHMAN
___ SOPHOMORE
___ JUNIOR
___ SENIOR
___ GRADUATE MA/MS
___ GRADUATE PH.D.
___ INTERNATIONAL
___ SPECIAL STUDENT
___ TRANSFER
___ VISITING STUDENT

RACE/ETHNIC GROUP
___ ASIAN/PACIFIC ISLANDER
___ AFRICAN AMERICAN/BLACK
___ BI-RACIAL
___ CAUSASIAN/WHITE (NON-HISPANIC)
___ HISPANIC/LATINO
___ OTHER
PLEASE LIST: ________

COMMUNICATION MODE
___ AMERICAN SIGN LANGUAGE
___ FINGER SPELLING
___ HOME SIGNS/GESTURES
___ LIP READING
___ ORAL
___ PIDGEON SIGNED ENGLISH
___ RESIDUAL HEARING
___ SIGNED ENGLISH
___ TACTILE SIGN
___ TRACKING SIGN
___ VOICE AND SIGN
___ OTHER
PLEASE LIST: ________

FINANCIAL SUPPORT
___ COLLEGE WORK STUDY
___ FULL-TIME EMPLOYMENT
___ GRANT
___ LOAN
___ PARENTS
___ PART-TIME EMPLOYMENT
___ SCHOLARSHIP
___ SSI/SSDI
___ STIPEND
___ VETERANS
___ VOCATIONAL
___ REHABILITATION
___ OTHERS
PLEASE LIST: ________

Optional
IF RECEIVING VOCATIONAL REHABILITATION, PLEASE LIST YOUR COUNSELOR:

PHONE: ________________
E-MAIL: ________________

Updated January, 2013
Tell us about your disability or disabilities...

**TYPE OF DISABILITY**

<table>
<thead>
<tr>
<th>Primary Disability</th>
<th>Secondary Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATTENTION DEFICIT DISORDER (ADD/ADHD)</td>
<td></td>
</tr>
<tr>
<td>AIDS/HIV</td>
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<tr>
<td>AMPUTATIONS</td>
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<tr>
<td>ARTHRITIS</td>
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<td>BURNS</td>
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<td>CANCER</td>
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<tr>
<td>CARDIOVASCULAR DISORDER</td>
<td></td>
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<tr>
<td>CELEBRAL PALSY</td>
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<tr>
<td>DIABETES</td>
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<tr>
<td>EPILEPSY</td>
<td></td>
</tr>
<tr>
<td>FIBROMYALGIA</td>
<td></td>
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<tr>
<td>HEARING IMPAIRMENT/DEAFNESS</td>
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</tr>
<tr>
<td>LEARNING DISABILITY</td>
<td></td>
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<tr>
<td>MENIERES DISEASE MULTIPLE</td>
<td></td>
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<tr>
<td>SCLEROSIS NEUROMUSCULAR DISABILITIES</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL DISABILITIES</td>
<td></td>
</tr>
<tr>
<td>PSYCHOLOGICAL/PSYCHIATRIC DISABILITIES</td>
<td></td>
</tr>
<tr>
<td>PULMONARY DYSFUNCTION</td>
<td></td>
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<tr>
<td>STROKE/CEREBRAL TRAUMA</td>
<td></td>
</tr>
<tr>
<td>TRAUMATIC BRAIN INJURY (TBI)</td>
<td></td>
</tr>
<tr>
<td>VISUAL IMPAIRMENT/BLINDNESS</td>
<td></td>
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<tr>
<td>OTHERS</td>
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</tbody>
</table>

**PRIMARY DISABILITY**

<table>
<thead>
<tr>
<th>AGE OF ONSET</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>DEGREE OF DISABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>MILD</td>
</tr>
<tr>
<td>MODERATE</td>
</tr>
<tr>
<td>SEVERE</td>
</tr>
</tbody>
</table>

**TREATMENTS**

MEDICATIONS *(include dates)*:

SURGERIES *(include dates)*:

**SUPPORTIVE SERVICES RECEIVED**

| COMMUNICATION THERAPY | |
| OCCUPATIONAL THERAPY | |
| ORIENTATION AND MOBILITY TRAINING | |
| PHYSICAL THERAPY | |
| PSYCHOLOGICAL COUNSELING | |
| SELF-CARE THERAPY | |
| SPEECH & COGNITIVE THERAPY THERAPY | |
| VISUAL THERAPY | |

Updated January, 2013
Do you use these ASSISTIVE DEVICES?

___ BRACES
___ BRAILLE
___ CANE
___ CART
___ CLOSED CIRCUIT TELEVISION
___ CRUTCHES
___ DPS 11-LARGE PRINT COMPUTER
___ ENLARGED PRINT
___ GLASSES/SUNGLASSES
___ GUIDE DOG
___ JAWS
___ KURZWEIL READER
___ MAGNIFYING DEVICES
___ MONOCULAR
___ PERKINS BRAILLER
___ SCREEN READER SOFTWARE
___ TELEBRAILLE
___ WALKER
___ MANUAL WHEELCHAIR
___ POWERED WHEELCHAIR
___ ZOOMTEXT
___ OTHERS

PLEASE LIST: ____________________

What ACCOMMODATIONS will you be requesting at Gallaudet University?

___ ADAPTIVE TECHNOLOGY
___ ADVOCACY TRAINING
___ BOOKS IN ELECTRONIC FORMAT (E-BOOKS)
___ BRAILLE/LARGE PRINT CART
___ COURSE SUBSTITUTION
___ DISABILITY COUNSELING
___ DORMITORY ACCOMMODATIONS
___ EARLY REGISTRATION
___ EXTENDED STUDY TIME
___ EXTENDED TIME ON ASSIGNMENTS
___ INTERPRETING SERVICES
___ MOBILITY TRAINING
___ NOTE TAKING SERVICES
___ READER/SCRIBE
___ REDUCED COURSELOAD
___ STUDENT ADVISORY BOARD
___ TESTING ACCOMMODATIONS
___ SIGN LANGUAGE INTERPRETING
___ WHEELCHAIR REPAIR
___ VOICE INTERPRETING
___ OTHERS

PLEASE LIST: ____________

Updated January, 2013
Please answer the following questions:

A) I AM A STUDENT WITH A DISABILITY OR DISABILITIES WHO HAS LEARNING AND PERFORMANCE STRENGTHS IN THESE AREAS:

______________________________________________________________

______________________________________________________________

B) DESCRIBE HOW YOUR DISABILITIES IMPACT YOU NOW:

______________________________________________________________

______________________________________________________________

C) MY STRONG POINTS IN THE ACADEMIC ENVIRONMENT ARE:

______________________________________________________________

______________________________________________________________

D) IF APPLICABLE, HAVE YOU BEEN TRAINED TO USE ADAPTIVE TECHNOLOGY?

______________________________________________________________

______________________________________________________________

E) HOW DOES YOUR DIAGNOSIS/MEDICATIONS AFFECT YOUR ABILITY TO FUNCTION EFFECTIVELY ON-CAMPUS?

______________________________________________________________

______________________________________________________________

Updated January, 2013
1. REASON FOR REQUEST OF SERVICES

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

2. OBSERVATIONS/COMMENTS

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

3. REASON FOR LEAVING PROGRAM
   _____ ACADEMIC DISMISSAL
   _____ GRADUATION
   _____ WITHDREW (MEDICAL, PERSONAL, ETC)
   _____ FOUND EMPLOYMENT
   _____ TRANSFER TO ANOTHER SCHOOL
   _____ FINANCIAL
   _____ OTHER

________________________________________________________________________

DATE OF LEAVING OR BEING TERMINATED FROM THE PROGRAM:

________________________________________________________________________

Updated January, 2013