FLORIDA GATEWAY COLLEGE
149 S.E. College Place Lake
City, FL 32025-2007

Accessibility Services Office
386.754.4393
Fax 386.754.4893
accessibility.services@fgc.edu

Instruction Sheet for Intake

The following are instructions for completing the enclosed documents. Please complete only the highlighted items on each form.

Reminder: These forms are required at your intake appointment.

1. Memorandum of Understanding
   a. Please read the information and write down any questions you have.
   b. Print, sign and date if you understand and agree to the items listed above.

2. Application for Services
   a. Please fill out the student information.
   b. When providing documentation for each disability requiring accommodations, please send us a recent doctor's note (dated within the last 2 years) or use the provided forms for your disability. If you need a new medical form or have the wrong one please notify the Accessibility Services Office.
   c. Please list your disability(ies) and what accommodations you are requesting (requesting accommodations does not guarantee them).

3. Self-Disclosure Information Form
   a. Print name and provide your student ID number (SID)
   b. For "other health impairments", please include such things as seizures, diabetes, severe allergies, narcolepsy, special medical care, etc.
   c. For "any aids", please indicate if there are any items that you may require, such as, wheelchair, hearing aids, medical pump, pacemaker, etc.
   d. For impact, please provide any additional provide any additional information about yourself, your disability and how it affects you especially with regard to your academic needs.

4. Documentation Verification Form
   a. This form MUST be completed by a licensed professional qualified to diagnose and treat the condition (e.g., medical professional, psychiatrist, licensed psychologist, licensed social worker, etc.).

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Application for Services / Self Identification

Students requesting accommodations at Florida Gateway College must self-identify, submit qualifying documentation, and complete this application prior to meeting with the campus coordinator. Completion of this form does not guarantee services. You will be contacted for an intake interview.

Student ID #: _____ Date: _____

Name: _____ Cell #: _____

Home / FGC email: _____

Emergency Contact Name: _____

Relationship: _____ Cell #: _____

Please provide documentation for each disability requiring accommodations.

Did you submit documentation of your disability including a diagnosis? ☐ Yes ☐ No

What is (are) your disability(ies)? _____

_____

Based on your disability, which academic accommodations are you requesting, and why?

_____

_____

Classroom Accommodations: _____

_____

Testing Accommodations: _____

_____

What is your major/career pathway? _____

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☐	Documentation complete	☐	Approved
		☐	Disapproved
☐	Documentation incomplete:		
☐	Intake interview (Date / time):		

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Self-Disclosure Information Form (1 of 2)

Student Information

Name: _____ SID: _____

Which semester are you requesting accommodations to start? ☐ Fall ☐ Spring ☐ Summer

Please indicate if you are a:

- ☐ Veteran / Active Duty Military / Reserves
- ☐ Vocational Rehabilitation student
- ☐ Dual Enrollment
- ☐ None of these

Disability Information

What is your disability? _____

_____

Other Health Impairment (i.e., diabetes, seizures, narcolepsy, severe allergic reactions):

_____

Indicate any aid you may be using (i.e., wheelchair, hearing aid, medicine pump, pacemaker)

_____

_____

Impact:

Check all that are impacted as a result of your disability.

- ☐ Listening
- ☐ Seeing
- ☐ Speaking
- ☐ Note-taking
- ☐ Computer use
- ☐ Sitting/Standing
- ☐ Walking
- ☐ Manipulating objects
- ☐ Managing internal distractions
- ☐ Managing external distractions
- ☐ Stress management
- ☐ Meeting deadlines/due dates
- ☐ Making and keeping appointments
- ☐ Attending class regularly/on time
- ☐ Organizational skills
- ☐ Time management
- ☐ Social interactions
- ☐ Memory
- ☐ Processing information
- ☐ Eating
- ☐ Self-care
- ☐ Sleeping

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Self-Disclosure Information Form (2 of 2)

Requested Accommodations:

Check accommodations you are requesting.

- ☐ Extended time on assignments/tests
- ☐ Step-by-step instructions (oral / written)
- ☐ Structured lists and schedules
- ☐ Oral review of dates/assignments
- ☐ Additional visual examples (PPT accessibility)
- ☐ Relate new knowledge to previous knowledge
- ☐ Minimize unnecessary classroom noise
- ☐ Allow breaks
- ☐ Alternate textbook format
- ☐ Grammar/Spellchecker
- ☐ Use of 4 function calculator
- ☐ Formula sheets
- ☐ Allow alternate methods of solving problems
- ☐ Break down larger problems into smaller problems
- ☐ Master one component of a problem before adding the next component
- ☐ Other (explain): _____

- ☐ Alternate test format
- ☐ Minimal/No distractions on testing
- ☐ Use of highlighter / overlay
- ☐ Use of scratch paper
- ☐ Paper & pencil tests
- ☐ Alternate test format
- ☐ Captioning
- ☐ Preferential seating
- ☐ Recorder / Note-taker
- ☐ Reader / Scribe / Lab assistant
- ☐ ASL interpreter
- ☐ FM system
- ☐ Service animal
- ☐ Excused medical absences

_____

_____

_____

FOR OFFICE USE ONLY

Autism Spectrum Disorder	Traumatic Brain Injury	Hearing Impairment	Learning Disability
Behavioral/Emotional/Psychological Disability	Physical or Other Health Disability	Speech Impairment	Visual Impairment

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Memorandum of Understanding

1. Eligibility and Documentation

- Students must provide appropriate documentation of a disability from a qualified professional in order to be considered for accommodations.
- OAS will review the documentation in accordance with federal and state law and institutional policy to determine eligibility.

2. Responsibilities of the Office of Accessibility Services

OAS agrees to:

- Review accommodation requests in a timely manner.
- Maintain confidentiality of disability-related records in compliance with applicable laws.
- Provide guidance to faculty and students regarding the implementation of accommodations.

3. Responsibilities of the Student

The student agrees to:

- Provide required documentation and complete the application process.
- Actively participate in the interactive process with OAS staff to identify reasonable accommodations.
- Request accommodations in a timely manner each semester or as needed.
- Communicate approved accommodations to faculty/staff as authorized by OAS.
- Communicate with instructors and OAS staff if accommodations are not effective or if concerns arise.
- Uphold Florida Gateway College's academic and behavioral standards.

4. Limitations

- Accommodations are not retroactive and begin only after approval by OAS.
- Accommodations do not alter essential course requirements, academic standards, or program objectives.
- OAS cannot guarantee success but will provide support to ensure equal access.

5. Acknowledgment

By signing this MOU, the student acknowledges that they understand their rights and responsibilities, and OAS affirms its commitment to providing reasonable accommodations in accordance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and institutional policy.

Student Name (Print): _____

Student Signature: _____ Date: _____

DOCUMENTATION VERIFICATION FORM

The Office of Accessibility Services (OAS) at Florida Gateway College provides accommodations and services for students with disabilities with the intent to help facilitate equal access to educational opportunities. This form must be completed by a licensed professional qualified to diagnose and treat the condition (e.g., medical professional, psychiatrist, licensed psychologist, licensed social worker).

Applicant: Complete the first section of the form and give the form to your provider for completion:

Student Authorization Section

I (print student name), _____, authorize (provider name),

_____, to complete and provide a

copy of this form to Florida Gateway College OAS.

_____ _____ _____

Student Signature Date of Birth Signature Date

Healthcare Provider Section

The following information is to be completed and signed by the provider

Date of first contact with your office: _____

How often is the patient seen? _____

Date of last contact: _____

Date of Diagnosis	Diagnosis	DSM-V or ICD Codes	Anticipated Duration of Diagnosis

Check off all sources used to verify diagnosis:

	Psychological testing		Family history
	Neuropsychological testing		Medical evaluation
	Psychoeducational testing		Diagnostic (X-ray, lab work, MRI, etc.)
	Structured or unstructured interview		Medical history supporting current presentation of symptoms
	Behavioral observations		Other:
	Academic history Individualized Education Plan (IEP), 504 Plan, teacher reports, etc.		_____ _____ _____

Current Treatment:

___ Medication Management: List any side effects that may impact academic performance:

_____

___ Outpatient Counseling/Therapy - Number of visits per month: _____

___ Physical/Occupational Therapy - Number of visits per month: _____

___ Speech Therapy – Number of visits per month: _____

___ Other (please describe):

_____

Explain how the student's disability impacts performance in a classroom setting (e.g., speaking, note taking, concentration, processing speed):

Explain how the student's disability impacts performance on timed tests (e.g., levels of anxiety/stress, memory, concentration, processing speed):

If applicable, explain how the student's disability might impact their ability to speak in front of a class (e.g., class participation, public speaking):

Please provide any additional information you feel will be useful in determining appropriate accommodations and services:

Complete this section ONLY when chronic health conditions impact attendance and/or course deadlines:

How often do medical episodes occur and how long do the symptoms last?

_____

Describe the impact of the symptoms:

_____

Date of last known episode:

_____

Does the episode/condition require hospitalizations? ___ Yes ___ No If yes, typical duration:

_____

Does the condition require regular treatments such as infusions, radiation? ___ Yes ___ No If yes, describe the side effects.

_____

Any upcoming surgeries related to the condition: If yes, date and expected recovery time?

_____

Healthcare Provider Information

Please attach business card

I certify by my signature that all information in this document is accurate and the patient is under my care.

Signature: _____ Date: _____

Print Name: _____ Title: _____

State of License: _____ License Number: _____

Address: _____ City: _____

State: _____ ZIP Code: _____ Phone: _____

It is preferred that this completed document is returned directly to the requesting student. Alternatively, it can be submitted to the OAS by:

Email: accessibility.services@fgc.edu

FAX: (386) 754-4715

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