



**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.).



**FLORIDA GATEWAY  
COLLEGE**

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

## Office of Accessibility Services

386.754.4393

Fax 386.754.4893

[accessibility.services@fgc.edu](mailto:accessibility.services@fgc.edu)

### 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? \_\_\_\_\_

#### FOR OFFICE USE ONLY

☐ Documentation complete

☐ Approved

☐ Disapproved

☐ Documentation incomplete: \_\_\_\_\_

☐ Intake interview (Date / time): \_\_\_\_\_





**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:**

- |  |  |
|--|--|
| <input type="checkbox"/> Veteran / Active Duty Military / Reserves | <input type="checkbox"/> Vocational Rehabilitation student |
| <input type="checkbox"/> Dual Enrollment                           | <input type="checkbox"/> 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.**

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



**Self-Disclosure Information Form (2 of 2)**

**Requested Accommodations:**

**Check accommodations you are requesting.**

- |   |   |
|---|---|
| <input type="checkbox"/> Extended time on assignments/tests                                 | <input type="checkbox"/> Alternate test format              |
| <input type="checkbox"/> Step-by-step instructions (oral / written)                         | <input type="checkbox"/> Minimal/No distractions on testing |
| <input type="checkbox"/> Structured lists and schedules                                     | <input type="checkbox"/> Use of highlighter / overlay       |
| <input type="checkbox"/> Oral review of dates/assignments                                   | <input type="checkbox"/> Use of scratch paper               |
| <input type="checkbox"/> Additional visual examples (PPT accessibility)                     | <input type="checkbox"/> Paper & pencil tests               |
| <input type="checkbox"/> Relate new knowledge to previous knowledge                         | <input type="checkbox"/> Alternate test format              |
| <input type="checkbox"/> Minimize unnecessary classroom noise                               | <input type="checkbox"/> Captioning                         |
| <input type="checkbox"/> Allow breaks   | <input type="checkbox"/> Preferential seating               |
| <input type="checkbox"/> Alternate textbook format  | <input type="checkbox"/> Recorder / Note-taker              |
| <input type="checkbox"/> Grammar/Spellchecker   | <input type="checkbox"/> Reader / Scribe / Lab assistant    |
| <input type="checkbox"/> Use of 4 function calculator                                       | <input type="checkbox"/> ASL interpreter                    |
| <input type="checkbox"/> Formula sheets   | <input type="checkbox"/> FM system                          |
| <input type="checkbox"/> Allow alternate methods of solving problems                        | <input type="checkbox"/> Service animal                     |
| <input type="checkbox"/> Break down larger problems into smaller problems                   | <input type="checkbox"/> Excused medical absences           |
| <input type="checkbox"/> Master one component of a problem before adding the next component |   |
| <input type="checkbox"/> Other (explain): _____   |   |
| _____   |   |
| _____   |   |
| _____   |   |

**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



**Memorandum of Understanding**

As a student seeking services through the Office of Accessibility Services (OAS) at Florida Gateway College,

- 1) I will take into account the following information when requesting my accommodation and/or test letters to ensure timely delivery to my instructors:

For Fall, Spring, Summer A12*	
Request by:	Sent to student by:
▪ 20 days** prior to first day of classes	▪ First day of classes
▪ 19 - 1 day(s)** prior to first day of classes	▪ Fifth day of classes
▪ After first day of classes	▪ After fifth day of classes

\*Contact OAS for mini-mester dates

\*\*Calendar days

**NOTE: Accommodations are not retroactive.**

- 2) I will report any academic difficulties to my advisor as they occur in order to discuss whether additional assistance is needed. Always check with your instructor first as he/she may be able to offer additional suggestions and/or help.
- 3) I will take care of all equipment or resources loaned to me and return it in working order after my last final exam for the term. Failure to do so will result in being charged for the item(s) and grade reports will be withheld until payment is received.
- 4) I will show up for my class even if I am receiving note-taking or video-recording services. Notes and video recordings are not a substitute for attending class. If notes or video-recordings are not picked up, the service is subject to being withdrawn.
- 5) I will check with my academic advisor before dropping or withdrawing from a class.
- 6) Information regarding a student's disability provided to the Office of Accessibility Services (OAS) is considered confidential and cannot be released to individuals or agencies outside the college without a student's signed consent. Disability records are covered under the Family Educational Rights and Privacy Act (FERPA). Under FERPA, information regarding a student's disability can be legally subpoenaed. It can also be released to Florida Gateway College administration if there is a threat to self or others or if there is a legitimate educational need to know.

I understand and agree to the items listed above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



## 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

Florida Gateway College does not discriminate against any person on the basis of race, color, ethnicity, religion, sex, pregnancy, age, marital status, national origin, genetic information, sexual orientation, gender identity, veteran status or disability status in its programs, activities and employment.

**Check off all sources used to verify diagnosis:**

<input type="checkbox"/>	Psychological testing	<input type="checkbox"/>	Family history
<input type="checkbox"/>	Neuropsychological testing	<input type="checkbox"/>	Medical evaluation
<input type="checkbox"/>	Psychoeducational testing	<input type="checkbox"/>	Diagnostic (X-ray, lab work, MRI, etc.)
<input type="checkbox"/>	Structured or unstructured interview	<input type="checkbox"/>	Medical history supporting current presentation of symptoms
<input type="checkbox"/>	Behavioral observations	<input type="checkbox"/>	Other: _____ _____ _____
<input type="checkbox"/>	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](mailto:accessibility.services@fgc.edu)

FAX: (386) 754-4715

**Florida Gateway College  
Office of Accessibility Services  
149 S.E. College Place  
Lake City, FL. 32025**