Services to students with disabilities, as part of the Center for Student Success, strives to ensure that qualified students with acquired brain injuries/disabilities are accommodated and if possible that these accommodations do not jeopardize successful therapeutic interventions. The office does not modify requirements that are essential to the program of instruction or provide accommodations for persons whose impairments do not substantially limit one or more major life function.

Calvin College is required by Section 504 of the Rehabilitation Act and the Americans with Disabilities Act to provide effective services for qualified students with documented disabilities if such accommodations are needed to provide equitable access to the College programs and services. Federal law defines a disability as a physical or mental impairment that substantially limits one or more major life activities. Major life activities are defined as the ability to perform functions such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. It is important to note that an acquired brain injury condition in and of itself does not necessarily constitute a disability. The degree of impairment must be significant enough to substantially limit one or more major life activities.

This form is designed to allow us to achieve these goals. Students who wish to receive academic adjustments due to acquired brain injuries/disabilities need to have this form filled out by a **certified physician**. The **physician** completing this form must have first hand knowledge of the students' condition, must have experience diagnosing and treating college students and will be an impartial professional who is not related to the student.

Release of Information

I, _____ , hereby authorize the exchange and release of the following confidential information to the Center for Student Success and Calvin College for the purpose of determining my eligibility for educational accommodation.

_____ _____

Date Student's Signature

Student Information (This section to be completed by the student)

Last Name First Name MI

Phone _____ Fax _____

License/Certification number and state of license _____

Signature: _____

Date of initial contact with student _____ Date of last contact _____

Diagnosis: