COLLEGE of SOUTHERN MARYLAND | Disability Support Services

La Plata • Leonardtown • Prince Frederick • Regional Hughesville

Returning Disability Support Services Student Application

Semester: _____ **Year:** _____

General Information:

Name: _____

Today's Date: _____ **Student ID Number:** _____

Primary Phone: _____ **Secondary Phone:** _____

Street Address: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Email: _____

Campus Attending:

☐ La Plata ☐ Leonardtown ☐ Prince Frederick ☐ Waldorf ☐ Hughesville

Other:_____

Employment Status:

☐ Full Time ☐ Part Time ☐ Unemployed

List accommodations that were successful for you in your previous semester.

List accommodations you are requesting for this semester:

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Please update your disability information:

Medication:

Update medications you are currently prescribed and/or taking and any side effects of these medications that adversely affect your daily activities: _____

_____

_____

Check all documented disabilities that apply to you:

☐	ADD – attention deficit disorder	☐	Mental or Emotional Disorder: Specify Below
☐	ADHD – Attention-Deficit/Hyperactivity		
☐	Arthritis (Severe)		
☐	Autism Spectrum Disorder or Asperger's Syndrome	☐	Mobility Impairment
☐	Cancer	☐	Multiple Sclerosis
☐	Cerebral Palsy	☐	Muscular Dystrophy
☐	Diabetes	☐	Orthopedic Impairment Specify Below
☐	Epilepsy/Seizure Disorder		
☐	Hearing Impaired:	☐	Psychiatric Disorder Specify Below
	☐ Deaf		
	☐ Hard of Hearing	☐	PTSD - Post Traumatic Stress Disorder
☐	Heart Condition	☐	Speech Impairment
☐	Learning Disability: Specify Below	☐	Spinal Cord Injury
		☐	Stroke
☐	Loss of Limb	☐	Traumatic Brain Injury
☐	Medical Disability: Specify Below	☐	Visual Impairment
			☐ Blind
	Other:		☐ Low Vision

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Schedule:

Class	Instructor	Course Type	Day(s) Time (ex T:7a-8a, Th:1p-2p)	Building/ Room #

Continuing Education Program of Study: _____

Expected Date of Completion: _____

By signing I guarantee the information provided is correct to the best of my abilities.

X Signature: _____ **Date**: _____

Parent or guardian if student is under 18:

X Signature: _____ **Date**: _____

"No otherwise qualified individual with a disability shall, solely by reason of his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." - Section 504 of the Rehabilitation Act of 1973

A "qualified person with a disability" is defined as one who meets the requisite academic and technical standards required for admission or participation in the postsecondary institution's programs and activities.

If you would like to request this form in an alternative format, please contact Disability Support Services at 301-539-4720 or via email at DSS@csmd.edu

Si desea solicitar este formulario en un formato alternativo, comuníquese con los Servicios de Apoyo para-Personas con Discapacidades al 301-539-4720 o por correo electrónico al DSS@csmd.edu