Records Retrieval

I, _____ on ___/___/___ acknowledge that I am
(student name) (date)
retrieving a copy of all my documentation on file with Disability Services at Transylvania University and that once I take this information out of possession of Disability Services I am responsible for keeping this information private and secure. I have been made aware that a copy of my information will stay on file at Transylvania University.

____ Valid picture I.D. presented

_____	_____	___/___/___
(Student signature)	(Printed Name)	(date)
_____	_____	___/___/___
(Witness signature)	(Printed Name)	(date)