Application for Temporary Disability

_____ ___/___/___
(Student Name) (date)

_____ _____
(Student Email) (cell)

_____
(Residence Hall/ Indicate **OC** if living Off Campus)

- **Disability Information**

Please provide injury or health related details contributing to this need. Include date of onset, any mobility issues, if the use of a mobile aid is needed, and any other information that is pertinent to this request.

-
_____
_____
_____
_____

- **Accommodations Requested**

_____
_____
_____
_____

I acknowledge that I am requesting accommodations that are temporary and I agree to supply the Disability Services Office (see contact information below) with documentation from a physician and/or athletic staff within one week of requesting accommodations.

_____
(Student Signature)

Contact Information
Amber D. Morgan – Coordinator of Disability Services
Office: Old Morrison, 111
Phone: (859) 233-8502, Fax: (859) 233-8101.
Email: admorgan@transy.edu or disabilityservices@transy.edu

Disability Services Use Only

_____ ___/___/___
(Signature of DSC) (date)

Documentation Received ___(yes) ___/___/___ ___(no)
(date)

Accommodations are valid from ___/___/___ to ___/___/___
(date) (date)

Additional Information:


TRANSYLVANIA
UNIVERSITY