Juilliard

Office of Academic Support and Disability Services

DISABILITY IDENTIFICATION FORM

NAME: ____ DATE: ____________________

STUDENT ID: ________________________ GENDER: _____ AGE: _____ BIRTHDATE: ______________

Major: ____________ Degree:______________ Expected Graduation Date: ____________

Local Address: ____
Street address City State Zip

Home Address: ____
Street address City State Zip

Cell phone: ___________________ E-mail: ___________________________

Residence during school year: ___________________________

Disability Information:

______Permanent _______Temporary (If Temporary, indicate duration) _________________

Disability Documentation

◆Disability documentation must be on clinician's letterhead and include diagnosis, nature of disabling condition, limitations, any recommended accommodations and duration, if temporary. *(Please note all documentation must be submitted in English)*

◆Comprehensiveness and currency of disability documentation is essential to enable the Disability Support Services Committee to assess the appropriateness and necessity for accommodations consistent with disability needs, academic standards, and audition requirements.

◆No request for accommodation will be considered without sufficient documentation and signed release giving the Director of Disability Services permission to speak to your clinician. Release forms are available from the office.

◆Documentation should be submitted to:

Holly Tedder
Director of Disability Services & Associate Registrar
The Juilliard School
60 Lincoln Center Plaza New York, NY 10023
Fax: (212) 769-6438

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NATURE OF DISABILITY: *(CHECK ALL THAT APPLY)*

___ ADD/ADHD
___ CHRONIC MEDICAL CONDITION: Specify ________________________
___ EATING DISORDER: Specify ________________________
___ HEARING
___ LEARNING: Specify ________________________
___ MOBILITY: Specify ________________________
___ SPEECH
___ SUBSTANCE ABUSE: Specify ________________________
___ TRAUMATIC BRAIN INJURY
___ VISUAL: Specify ________________________
___ OTHER: Specify ________________________

BRIEFLY DESCRIBE YOUR DISABILITY (*Supporting medical documentation will be required):*

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WHAT TYPE OF ACCOMMODATIONS ARE YOU REQUESTING? ___________________________

Please briefly describe the accommodations you think you will need. (Allow at least 8 weeks' notice.)

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IN CASE OF EMERGENCY CONTACT:

NAME: ____

ADDRESS: ____

Street address City State Zip

TELEPHONE: ______________________________ RELATIONSHIP: _____________________

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Applicant Signature Date

Parent/Guardian if applicant is under 18 years of age

Signed ___________________________________ Date___________