FLINT HILLS TECHNICAL COLLEGE

DISABILITY FORM A

620.343.4600 | 800.711.6947 | FAX: 620.343.4610 www.fhtc.edu 3301 WEST 18TH AVENUE | EMPORIA, KANSAS 66801

AUTHORIZATION FOR RELEASE OF INFORMATION BY LICENSED PHYSICIAN OR PROFESSIONAL

To: _____
Doctor ect.

_____
Street Address

_____ _____ _____
City State Zip

Day Time Phone: _____ Evening Time Phone: _____

I, the undersigned student, am requesting special services from Flint Hills Technical College and hereby request and authorize you to release any information pertaining to my disability.

Student's Full Name: _____
Last First Middle JR., etc.

Date of Birth: _____ Social Security Number _____ - _____ - _____
mm/dd/yyyy

Signature of Student: ☐ By checking this box you have created an electronic signatureas legally binding as your hand-written signature. _____ Date: _____
mm/dd/yyyy

VERIFICATION

In order to provide the student with special educational services designed to help him/her be more successful in college, we require a verification of the students needs. Please provide the following information:

Diagnosis

Limitations Functional limitation(s) resulting from the condition/disorder that would, in your opinion impede the student's educational performance. Please check all that apply:

- ☐ Poor concentration, distractibility and/or confusion.
- ☐ Intense anxiety, phobia, and/or panic.
- ☐ Difficulty completing assignments due to pressures.
- ☐ Difficulty in taking notes, reading college texts, taking tests and/or managing time.
- ☐ Problems in hearing and/or speaking in class discussions.
- ☐ Other

☐ By checking this box you have created an electronic signatureas legally binding as your hand-written signature.

_____
Signature of Professional

_____ _____
Title Date

After a qualified professional has completed the disability verification section, please mail to: **Flint Hills Technical College, Attn: Dean of Enrollment Management, 3301 West 18Th Avenue, Emporia KS 66801**. Or email the completed pdf to **bcarmichael@fhtc.edu**.