

University of Arkansas at Monticello

Special Student Services Request for Accommodations

Name _____ SSN _____

Permanent Address _____ City, State _____

Campus Address (if applicable) _____

Permanent Phone _____ Cell Phone _____

Email _____ Major _____

Diagnosis: list your disabilities in the following areas

Fine Motor _____

Hearing _____

Learning _____

Mobility _____

Speech _____

Vision _____

Other _____

Describe your special needs and list any accommodations you are seeking _____

I request that Special Student Services notify my instructors of my disability.

Student Signature

Date

This release is effective for _____ calendar year(s) from the above date.

*Release is only valid for one year if no calendar year is entered in the space above.