FLORIDA ACADEMY

Application for Disability Accommodations

First Name: Last Name:

Address:

City: State: Zip Code:

Phone:

Email:

Projected Program/Position:

Projected Start Date:

Explain your disability and current treatment:

What accommodation are you requesting?

Do you take prescription medication relating to the disability for which you are requesting accommodation? If yes, please list the name(s), dosage and prescribing physician:

Do you receive assistance from Vocational Rehabilitation, Veteran's Affairs, Student Support Services or any other agency? If yes, please list the contact person and his/her location.

Once you apply for services and provide the appropriate documentation, the ADA Coordinator/Human Resources Director will review your documentation and inform you of your status as a student or employee with a disability.

Permission to Release Information

I_____, hereby give my permission to Florida Academy to discuss information concerning my disability and accommodations and/or to release documentation on my disability, with individuals who will be involved in the delivery of services to me for my benefit. I also give permission for other agencies and individuals to discuss and release information to the Florida Academy ADA Coordinator/Human Resources Director. In addition, pertinent information related to my disability may be provided to facilitate the delivery of services on a "need to know" basis. These individuals include, but are not limited to:

- Parents,
- Guardian,
- Spouse
- Faculty and staff of Florida Academy,
- Other professionals or agencies involved in services, support, accommodations or consultation

as deemed appropriate by the ADA Coordinator/Human Resources Director. For students, permission to release information will remain in effect until graduation. For employees, permission remains in effect throughout the term of employment with Florida Academy Permission may be rescinded in writing at any time.

_____ _____

Signature of Student/Employee Date Signed

_____ _____

ADA Coordinator/ HR Director Date Signed

Notice to Party Receiving Information: This information has been disclosed to you from records whose confidentiality is protected by federal law which prohibits you from making further disclosure of information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Disability Accommodation Letter

The student/employee listed below has registered with the ADA Coordinator/ Human Resources Director as having a documented disability that will require accommodations. This means that (s)he is eligible for services that give equal access to higher education/ employment under the guidelines of Section 504 of the Rehabilitation Act of 1973 (as amended) and the Americans with Disabilities Act of 1990. Please discuss these accommodations with the student/employee and immediately contact the ADA Coordinator/Human Resources Director if there are any concerns. Florida Academy is committed to ensuring that all information regarding a student/employee is maintained as confidential as required or as permitted by law. Information in files will not be released without the student/employee's written permission except in circumstances mandated by federal or state law.

Student/Employee Name_____

Program/Position: _____

Accommodation Approved:_____

_____

_____

_____

_____

_____

_____

_____

Dates of Accommodation (If any): _____

_____

_____

ADA Coordinator/HR Director Signature Date Signed

For more information, please contact the ADA Coordinator or Human Resources Director.

FLORIDA ACADEMY

ADA GRIEVANCE FORM

Complainant:

Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

Faculty _____ Staff _____ Student _____ Other (specify)_____

Date and Time of Occurrence: _____

Location: _____

What happened? _____

_____

_____

_____

_____

Names and phone numbers of others who can verify what happened: _____

_____

_____

_____

What would you like to see happen (for you, for others) with respect to this issue? _____

_____

_____

_____

_____

Signature of Complainant Date

Respondent:

Name of person conducting interview: _____

Phone #: _____ Email: _____

Name of person(s) or group the complaint is against: _____

_____

_____

Phone #: _____ Email: _____

Phone #: _____ Email: _____

Faculty _____ Staff _____ Student _____ Other (specify) _____

What was the result of your discussion with the respondent?

_____

_____

_____

_____

_____

_____

Signature of Respondent Date

_____

Signature of Respondent Date

_____

Signature of Interviewer Date

Office Use Only

Actions Taken: _____

_____

_____