

# APPLICATION FOR ACCOMMODATION

The purpose of this application is to gather information to assist in providing reasonable accommodation for students with disabilities at Des Moines Area Community College (DMACC). Return this completed Application for Accommodation, along with supporting documentation to:

Disability Services Office, Disability Services Coordinator  
Des Moines Area Community College  
2006 South Ankeny Blvd., Bldg. 6-10A  
Ankeny, IA 50023-3993  
FAX: (515) 965-7150 Phone: (515) 964-6234

\_\_\_\_\_  
Student's First Name Preferred Name Middle Last Name  
Initial

\_\_\_\_\_  
Student's Address City State, Zip

\_\_\_\_\_  
Phone Number Campus DMACC ID#

- Current Student  Fall  Spring  Summer Program of Study \_\_\_\_\_  
 Credit classes  Non-credit  WTA  ELL  Cont. Ed  HiSET  
 Career Academy Program of Study \_\_\_\_\_ Campus \_\_\_\_\_

**Please explain how your disability affects, limits, or impacts you as a student by completing the following:**

What is your disability?

How does your disability affect your daily life and academics?

Specify the nature of the requested accommodation(s), including any equipment, aids, or services:

- |                                                               |                                                 |                                                     |
|---------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Testing Outside Classroom            | <input type="checkbox"/> Instructor PowerPoints | <input type="checkbox"/> Preferential Seating       |
| <input type="checkbox"/> Extended Test Time                   | <input type="checkbox"/> Audio Record Lecture   | <input type="checkbox"/> Accessible Seating         |
| <input type="checkbox"/> Test Reader: Text-to-speech software | <input type="checkbox"/> Note taker             | <input type="checkbox"/> Sign Language Interpreters |
| <input type="checkbox"/> Textbooks in alternate format        | <input type="checkbox"/> Calculator             |                                                     |
| <input type="checkbox"/> Other _____                          |                                                 |                                                     |

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**Ankeny Campus**  
2006 S. Ankeny Blvd  
Ankeny, IA 50021-3993  
515-96-6200

**Boone Campus**  
1125 Hancock Dr.  
Boone, IA 50036-5399  
515-432-7203

**Carroll Campus**  
906 N. Grant Rd.  
Carroll, IA 51401-2525  
712-792-1755

**Newton Polytechnic  
Campus**  
600 N 2<sup>nd</sup> Ave. W.  
Newton, IA 50208-3049  
641-791-3622

**Urban/DSM Campus**  
1100 7th St.  
Des Moines, IA. 50314-3049  
515-244-4226

**West Campus**  
5959 Grand Ave.  
WDM. IA 50266-  
5302  
515-633-2407

Review Policy ES 4610 (Reasonable Accommodation for Students with Disabilities) for a full description of the application, evaluation, and appeal process associated with reasonable accommodation of an applicant for admission or student with a disability,

The Disability Services Coordinator will make a determination regarding your application within ten (10) working days of the date of this application and will inform you of the decision in writing or in some other form appropriate to your disability.

**Statement of Agreement:**

I (student) understand the DMACC Disability Services-Coordinator and/or Disability Services Office staff may have access to this Accommodation file, as well as academic and other records of the College, while maintaining confidentiality at all times. I further understand it may be necessary for the DMACC Disability Services Coordinator and/or Disability Services Office staff to release/exchange information with other DMACC staff with legitimate educational interest in regard to my education. By completing this form, I agree to such exchange of information. I understand this is effective for the duration of enrollment as a student at DMACC. I understand that if my circumstances change it is my responsibility to contact the Disability Services Office.

**Statement of Consent to Share Information:**

I understand my consent is effective for the duration of enrollment as a student at DMACC. I understand that if my circumstances change it is my responsibility to contact the Disability Services Office.

I (student) **give** the Disability Services Coordinator at DMACC permission to release/exchange information with third parties outside of DMACC: (Please check all that apply)

- Name \_\_\_\_\_ Relationship to student \_\_\_\_\_

**By signing, I agree my signature confirms I have completed this form.**

Printed Student Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_