IHCC Disability Services
Request for Services

The Disability Services office will review all requests. We are committed to ensuring that all information regarding a student is maintained as confidential. No one has immediate access to the student files at IHCC Disability Services except the Disability Services staff. Any information shall be considered confidential and shared with IHCC personnel on a need-to-know basis or as required or permitted by law.

To file a request for accommodations, follow the steps below.

**Request for Services Checklist**

1. Student should complete the Request for Services form below.
2. Complete the [Release of Confidential Information](#) form.
3. Schedule a meeting with the Disability Services Office to discuss approved accommodations, the accommodation form process, and explain how to have a conversation with instructors.

   Ottumwa Campus
   Pothoven Academic Success Center 101C
   525 Grandview Ave.
   Ottumwa, IA 52501
   Phone: (641) 683-5749
   Email: disabilityservices@indianhills.edu

   Centerville Campus
   Administration Building
   721 N. 1st Street
   Centerville, IA 52544
   Phone: (641) 683-5181

4. An accommodation form will be emailed individually to each instructor. It is the student’s responsibility to discuss their accommodations with the instructor, and how they will be implemented.
5. Following the initial request, students must submit their class schedule to the Disability Services office each term to initiate accommodation forms.
6. The student can contact the Disability Services office at any time if they are having issues implementing or receiving accommodations. Accommodations are not retroactive, therefore, you should contact the Student Disability Services office in a timely manner to ensure coordination.

**Release of Confidential Information Form**

**Section I: Student Information**

Student’s Name: ________________________________  (Last)  (First)  (Middle Initial)

IHCC ID Number (if available): ____________________  Phone Number: ____________________

Address: _____________________________________________

City: ___________________________________________  State: _______  Zip: ____________
Email Address: ________________________________

Anticipated Start Term: ___________ Anticipated/Current Program: _______________________________________

Disability: ____________________________________________________

Please describe how the disability limits or affects you as a student:
__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

What types of accommodations have you had in the past?
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Section II: Documentation (to be completed by the appropriate licensed professional)

Documentation is required before requests for accommodations can be finalized the documentation of the disability by the appropriate licensed professional is required. For documentation, you may wish to contact your Vocational Rehabilitation counselor, physician, psychologist, or other appropriate licensed professionals.

Description of the disability:
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Description of how the disability affects, limits, or impacts the student:
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

What assessment procedures and/or evaluation instruments were used to make the diagnosis?
__________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________

Will medication impact the student’s ability to meet the demands of the postsecondary environment?  
☐ Yes  ☐ No  If yes, describe how:
________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________________
Recommended Accommodations:

Please provide a list of appropriate accommodations recommended. Example: Extended test time (time and a half)

_________________________________________________________________________

_________________________________________________________________________

Other comments:

_________________________________________________________________________

_________________________________________________________________________

Please supply any additional information that may be helpful.

Evaluator’s Name: ___________________________ Title: ___________________________

License Number: ___________________________ Phone Number: __________________

Address: ________________________________________________________________

Signature: ___________________________ Date: ___________________________

Indian Hills Community College will make every effort to provide reasonable accommodations in accordance with the Americans with Disabilities Act (ADA). Services provided will not lower any course standards or change any requirements of a particular degree. The services are intended to allow equal access for students with disabilities.