Print Form

COLLEGE OF CHARLESTON

Center for Disability Services
Phone (843) 953-1431
SC Relay System 1-800-735-2905

LCTR 104
160 Calhoun Street

Charleston, South Carolina 29424
Fax (843) 953-7731
SNAP@cofc.edu

CDS/SNAP APPLICATION

NAME: _____ SID#: _____
Last First MI

Charleston Mailing address

Permanent mailing address

Phone _____ Phone _____

E-mail _____ E-mail _____

Class Status: ○ Freshman ○ Sophomore ○ Junior ○ Senior

Status: (check all that apply) ☐ Regularly admitted ☐ Provisional ☐ Re-admit

☐ Continuing Education ☐ Transfer ☐ In good standing ☐ Probation

Major(s): _____ Minor(s): _____

Employed: no Hours worked/week _____

I am applying for services (check all that apply):

☐ based on a learning disability
☐ based on a learning disability and I am requesting alternatives to the foreign language requirement
☐ based on a learning disability and I am requesting alternatives to the math/logic requirement
☐ based on a learning disability and I am requesting alternatives to both the foreign language and math/logic requirement

☐ based on attention deficit

☐ based on other (please indicate): _____

Did you take the Modern Language Aptitude Test (MLAT) at the College of Charleston? no

If yes, indicate score here. _____

List strengths (academic and non-academic)

What strategies or techniques have you used in the classroom or studying that have been successful?

What techniques do instructors use in the classroom that have been especially helpful to you?

Have you been granted accommodations in the past? no If yes, list them here.

What accommodations or academic adjustments do you anticipate that you will need to request?

Consent and Authorization to Release Information

Pursuant to Federal Guidelines concerning my right to confidentiality and state law concerning privileged communication

I, _____, _____
(Print Name) (Student Identification Number)

authorize CDS/SNAP to release my documentation to: (**initial** all that you consent to release information)

_____ the College of Charleston's review committee. This committee will assess the evaluation to ensure that it meets the College of Charleston's criteria, that the documentation supports the diagnosis(es) and that reasonable accommodations are identified.

_____ my professors _____ Director may discuss my strengths and weaknesses with my professors

The Family Education Rights and Privacy Act of 1964 prohibits the release of college information to family members. However, you may designate those with whom a CDS/SNAP advisor may discuss your academic situation (normally family members or guardian).

mother father

This authorization shall expire upon graduation, my transferring to another institution, or upon my withdrawal from the College of Charleston. I understand that I may revoke this consent to release information at any time prior to the stated conditions. I also understand that any release made between the time I authorize it and then revoke it shall not constitute a breach of my right to confidentiality.

_____ _____
(Student Signature) (Date)