

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#: _____
(Please print) Last First MI

Charleston Mailing address

Permanent mailing address

Phone _____

Phone _____

Email _____

Email _____

CLASS STATUS: (circle one) Fr. So. Jr. Sr.

STATUS: (check all that apply) _____ Regularly admitted _____ Provisional _____ Re-admit

_____ Continuing Education _____ Transfer _____ In good standing _____ Probation

MAJOR _____ MINOR _____ EMPLOYED _____ Hours Worked/wk _____

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 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? _____ If yes, indicate score _____.

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? _____ If yes, list them _____

What accommodation 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).

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)