Temporary Disabilities

Disability Services offers academic accommodations to students with temporary disabling conditions. Examples of temporary disabilities may include, but are not limited to: broken limbs, hand injuries, or short term impairments following surgery or medical treatments. The Office of Disability recognizes the importance of having appropriate services and resources available for all students with temporary and permanent disabling conditions. For more information, please contact the Disability Coordinator (361) 354-2728 or email disability@coastalbend.edu.

Application Process

1. Fill out and submit the Request for Temporary Services Form to your nearest CBC location along with your current class schedule.

2. Submit appropriate medical documentation from a licensed professional such as a medical doctor.

**Medical documentation must:**

- Provide information regarding the student's specific disability
- Describe functional limitations (In an educational setting.)
- Describe specific accommodations
- Provide side effects caused by medications (if any)
- Establish the evaluator’s credentials (License, Specialization, etc.)
- Be written on official letterhead and signed

3. Call and set-up an appointment with the Disability Coordinator to review documentation and discuss possible accommodations.

4. After academic accommodations have been discussed and approved, a letter will be given to the student and instructor with the approved services for the semester. It is your responsibility as a student, to discuss all accommodations needed with the instructor and testing center after receiving initial approval for academic services from Disability Services Office.

    *** Additional documentation may be requested to verify the need for continued services after the estimated duration of the condition has expired. ***

Academic accommodations are approved on a case-by-case basis. Examples of accommodations:

- Note takers
- Scribes for Exams
- Tape Recorder for Lectures
- Extended Testing Time

Disability Services **DOES NOT** provide personal assistance to students with temporary disabilities such as building-to-building transportation or the transport of books or other personal items. Wheelchairs, scooters and other mobility devices are considered personal devices and are not provided by Disability Service.
Request for Temporary Services

Semester Attending: _________________________________  Today’s Date: ______________________
(fall, spring, summer)  (Year)

Name:_____________________________________________ CBC ID#________________________

Address:..............................................................................................................................
Street Address                                 City                       State                                 Zip

Phone: _______________________________ Email: ___________________________________

Date of Birth:___________________________ Gender (Please Check One): _____ Male _____ Female

CBC Location (Please Check One):_______ Alice _______ Beeville _______ Kingsville ______ Pleasanton

Career Goal/Major:___________________________________________________________________

Cougar Sport (if applicable):
____ Baseball  _____ Basketball  _____ Volleyball  _____ Softball  _____ Soccer

Disability Information:

____ Health/Medical      Type: __________________________
____ Physical*           Type: _________________________
____ Traumatic/Acquired Brain Injury/Concussion*
____ Other: __________________________

Please describe the cause of your injury:

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Date of injury: __________________________ Duration: _________________________________

Date of follow-up doctor visit: ________________________________

If physical:

Level of Mobility:

Arm/Hand
• Dexterity: ______ All ______ None ______ Limited
• Which hand: ______ Left ______ Right ______ Both
• Which hand do you write with: ______ Left ______ Right
Leg/Foot

- Which Leg/Foot: ________ Left ______ Right ______ Both
- Mobility Device Requirements:
  _____ Electric Wheelchair  _____ Manual Wheelchair  _____ Scooter
  _____ Other (Walker, crutches, cane, etc.)

If Traumatic/Acquired Brain Injury/Concussion:

- Was this your first head trauma: _____ Yes _____ No
- If no, how many have you had prior to now: _____ 1 _____ 2+
- Have you seen a neurologist: _____ Yes _____ No

Please list any related medications you are taking:

Name: ___________________ Purpose: ___________________ Start date: __________ Dosage: ______
Name: ___________________ Purpose: ___________________ Start date: __________ Dosage: ______

Please explain how the medication helps you:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Functional Limitations: Please check off the activities listed below that you believe are affected as a result of your diagnosis.

1 = No Impact  2 = Mild Impact  3 = Moderate Impact  4 = Significant Impact

|   | 1 | 2 | 3 | 4 | Major Life Activities               |   | 1 | 2 | 3 | 4 | Learning / Time Management            |
|---|---|---|---|---|-------------------------------------|---|---|---|---|---------------------------------------|
|   |   |   |   |   | Caring for Oneself                  |   |   |   |   | Memory                                |
| 1 |   |   |   |   | Talking                              |   |   |   |   | Concentrating                         |
| 2 |   |   |   |   | Hearing                              |   |   |   |   | Listening                             |
| 3 |   |   |   |   | Breathing                            |   |   |   |   | Organization                          |
| 4 |   |   |   |   | Seeing                               |   |   |   |   | Managing distractions                 |
|   |   |   |   |   | Walking                              |   |   |   |   | Timely submission of assignments      |
|   |   |   |   |   | Standing                             |   |   |   |   | Attending class regularly             |
|   |   |   |   |   | Lifting/Carrying                     |   |   |   |   | Managing and keeping appointments     |
|   |   |   |   |   | Sitting                              |   |   |   |   | Managing stress                       |
|   |   |   |   |   | Eating                               |   |   |   |   | Writing                               |
|   |   |   |   |   | Working                              |   |   |   |   | Spelling                              |
|   |   |   |   |   | Interacting with others              |   |   |   |   | Quantitative reasoning (math)         |
|   |   |   |   |   | Sleeping                             |   |   |   |   | Processing Speed                      |
Describe how your medical condition is currently impacting you.

__________________________________________________________________________________________________________________________________________________

Accommodations/Services:

- _____ extended test time  
- _____ oral testing  
- _____ special seating
- _____ permission to tape lectures  
- _____ note taker
- _____ Reader for exam  
- _____ tape recorder
- _____ special equipment/specific: ________________________________________________________________
- _____ other/specific: ___________________________________________________________________

SERVICES RECEIVED/REQUESTING: (Skip if this section does not apply to you)

<table>
<thead>
<tr>
<th>Campus Access</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I cannot walk long distances quickly</td>
</tr>
<tr>
<td></td>
<td>I cannot walk long distances at all</td>
</tr>
<tr>
<td></td>
<td>I cannot go up or down stairs and need access to an elevator</td>
</tr>
<tr>
<td></td>
<td>I use an assistive walking device that makes it difficult to get around independently during inclement weather</td>
</tr>
<tr>
<td></td>
<td>I use crutches</td>
</tr>
<tr>
<td></td>
<td>I use a cane</td>
</tr>
<tr>
<td></td>
<td>I use a wheelchair</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dining Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assistance Needed (access to food choices help with tray)</td>
</tr>
<tr>
<td></td>
<td>My medical condition requires me to be on a special diet</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Housing Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Single Room (for medical issues)</td>
</tr>
<tr>
<td></td>
<td>Accessible Room (elevator, space for chair/ equipment, etc.)</td>
</tr>
<tr>
<td></td>
<td>Bathroom Modifications (grab bars)</td>
</tr>
<tr>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Evacuation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assistance may be required to evacuate a building</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transportation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I am driving and need access to handicap parking close to my classes</td>
</tr>
</tbody>
</table>
Coastal Bend College does not discriminate on the basis of race, color religion, gender, national origin, age or disability in the recruitment and admission of students; the availability of grants and scholarships. No qualified disabled person shall, on the basis of being disabled, be subjected to discrimination in education, training, or employment. Inquiries or complaints concerning these matters should be brought to the attention of: Dean of Student Services.