



Learning Needs Disclosure Form

Wheaton College is committed to providing reasonable accommodations to ensure that all qualified students are provided full access to our programs and services. Students with disabilities who require accommodation(s) are encouraged to identify these needs by completing this form and returning it to the Filene Center for Academic Advising and Career Services preferably within the first two weeks of the semester.

IMPORTANT: An Individual Education Plan is not sufficient and must be accompanied by a psycho-educational evaluation and testing. Complete documentation of the disability diagnosis and recommended accommodations is required. If you have current documentation of your disability (completed within the past three years) that meets these requirements, please submit it with this form.

Student's Name (please print) _____ Wheaton ID # _____

I acknowledge the disclosure of my disability to Wheaton College. _____

Home Address _____ Home Phone _____ Student Signature _____

City, State, Zip _____

Campus/Cell Phone _____ E-mail _____

My disability can be categorized as (check as many as apply):

- | | |
|--|---|
| <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Mobility Impairment | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Deaf or Hard of Hearing | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Chronic physical disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Autism Spectrum Disorder |

Please describe any accommodations you have used previously including any Assistive Technology:

Are you registered for books on tape through the Reading for the Blind and Dyslexic RFB&D? If so, please include your member number and date of renewal. _____

**Please return to:
The Filene Center for Academic Advising and Career Services
Wheaton College, 26 East Main Street, Norton, MA 02766
Attn: Dean Denyse M. Wilhelm**

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For office use only: Updated GOAMEDI _____ (Date). _____ (Initials) _____
Medical Code: Disability Code: Equipment Code: Disability Service: