DEPARTMENT OF TESTING & DISABILITY SERVICES

DISABILITY SERVICES ACCESSIBILITY CONCERN FORM

Please complete this form to summarize the problem or concern you are experiencing.

NAME: _____ ID #: _____

TODAY'S DATE: _____ PHONE: _____

TECH E-MAIL: _____

NAME OF FACULTY or STAFF INVOLVED: _____

BEGINNING DATE OF PROBLEM/COMPLAINT: _____

DESCRIBE THE SITUATION AND THE NATURE OF THE PROBLEM OR CONCERN. You may attach other pages as needed to describe the problem clearly and completely.

IF APPLICABLE, IDENTIFY THE STEPS YOU HAVE TAKEN TO RESOLVE THE DIFFERENCES BETWEEN YOU AND THE INVOLVED FACULTY/STAFF. PLEASE INCLUDE A COPY OF ANY WRITTEN CORRESPONDENCE.

WHAT RESOLUTION ARE YOU SEEKING?

Important: If you do not receive a reply from Disability Services within 24 hours from the time you submitted this form online, please contact our office at 318-257-4221.