

TEMPORARY ASSISTANCE

Return completed forms in person or by email to Counseling and ADA Services:
Garland Library, Room 233
423-636-7300 ext. 5402

counselingandadaservices@tusculum.edu

Please provide the following information. For those questions that do not apply to your request, please answer N/A to indicate not applicable.

Last Name:	First Name:	MI:		
Preferred Name/Nickname:				
Pioneer Email:	Alternate Email:			
Student ID:	Major:			
Cell Phone: ()	Local Phone: ()			
Classification (Select One)Freshman	SophomoreJuniorS	SeniorGraduate		
Campus (Select one):GreenevilleKnoxvilleMorristownOnline				
Are you currently enrolled? Y N If no, anticipated start date:				
Course Schedule				
	I			

HEALTH CARE PROVIDER

Medical Doctor:	Psychologists/Psychiatrist:			
Current Medications:	(Name)		(Name)	
Diagnosis:				
·	1 0 0	lical affects you in the acade	emic/educational environment.	
What do you need whi	lle you recover fron	n your temporary injury/me	dical condition?	
Please initial by the in Temporary Assis	nformation includ			
Class Schedule				
			Once my file has been reviewed, ithin five business days on the	
Student Si	gnature		Date	
*******	*******	**********	***********	
For Office Use Only				
Date Received:				
Received by:				
Initial due date:				

CONFIDENTIAL RELEASE OF INFORMATION

The primary purposes of this release are to help ensure that I receive reasonable accommodations and counseling support services as needed at Tusculum. Authorized consent will remain in effect for the duration of my enrollment. I have the right to revoke the release of information at any time by completing and signing another Release of Information form.

I authorize Counseling and ADA Services to release information to the following entities:

(Please initial all that apply.)

______ Appropriate Tusculum faculty, staff, and administrators as needed

______ Standardized testing agents (e.g. GRE, LSAT, etc.) as specified:

______ Other Post-Secondary institutions as needed as specified:

______ Other off-campus professionals as specified (VR, MD):

______ Flag for mobility needs or priority registration in Registrar's Office

Other (parent, spouse, etc.):

PRINT NAME:

STUDENT ID:

SIGNATURE:

DATE:

WITNESS SIGNATURE:

DATE: