***This form to be completed by the individual requesting ADA accommodations***

By filling out this form, and by my signature below, I am giving permission for the release of any medical, educational, sociological, or psychiatric information between my diagnosing physician(s), the Platt College ADA Coordinator, and any other Platt College representative deemed to be in a "need to know" position.

Last Name: ______________________ First Name: ______________________ MI: ________

Date of Birth: ______________________ Home/Cell Phone: ______________________________

Email address:_______________________________________________________________

Home address:_______________________________________________________________

Beginning Quarter/Year this request applies: ____________________________________

Name and Title of Diagnosing Professional: ____________________________________

Address:____________________________________________________________________

City/State/Zip Code:__________________________________________________________

Phone Number:_______________________

Signature:________________________________________ Date: _______________________

**Return to:**

***Darla Dolph, MS, Academic Support and Career Services Coordinator***
***Phone: 303-369-5151 x 231, Email: darla.dolph@plattcolorado.edu***
***Platt College 3100 South Parker Road, Aurora, CO 80014***