



Office of Student Disability Services
Temporary Disability Registration Form

Name: _____
 First Middle Last

Name which you prefer to be called: _____

M Number: _____ Birthdate: _____ / _____ / _____
 Month Day Year

Local Mailing Address: _____
 Street or Box No. City State Zip

Cell Number: _____ - _____ - _____ Emergency Number: _____ - _____ - _____

Home (Permanent) Address: _____
 Street or Box No. City State Zip

Home (Permanent) Phone Number: _____ - _____ - _____

Present Year (circle one): Freshman Sophomore Junior Senior Graduate Other

Nature of Temporary Disability: _____

Accommodations Requested: _____

RELEASE FORM

I, the undersigned, give the director, program coordinator and/or staff of the Office Student Disabilities Services permission to release and/or obtain information concerning my diagnostic testing, grades, and other information to/from instructors, parents, assigned tutors, vocational rehabilitation counselors, and Murray State University administrative staff as necessary. This information will be used to assist the SDS staff in providing services to me. I understand that these individuals will keep this information confidential.

Signature _____

Date _____