275 Eastland Road
Berea, Ohio 44017
https://www.bw.edu/accessible-education
Email: disability@bw.edu
Fax: (440) 826-3832

(Please Print)

Name (Last, First, Middle): _____

Date of Birth: _____ BW ID Number: _____

Status (check one): ☐ current student ☐ transfer student ☐ prospective student

Phone: (_____) _____ - _____ BW Email: _____ @bw.edu

Address (street, city, state, zip code): _____

_____

I authorize the Office of Accessible Education (OAE) to:

☐ Release Information to ☐ Obtain Information from

Provider Name (Print): _____

Title: _____

Mailing Address: _____

_____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Unless otherwise revoked, this authorization shall remain in effect until _____.
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed. This authorization may be revoked at any time. The revocation must be in writing, signed by me or my representative, and delivered to the Office of Accessible Education (OAE). The revocation will take effect when OAE receives it, except to the extent that OAE or others have already taken action on this authorization.

By signing below, the student grants OAE permission to contact the provider for additional information.

I, _____ (printed name of student), hereby authorize OAE to obtain and/or release information from/to the provider indicated below in order to evaluate eligibility for academic accommodations.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

☐ By selecting this box, I verify that the information provided is correct, that I am currently treated or have been treated by the provider, and that