**ARAB OPEN UNIVERSITY**

**STUDENT DISABILITY/SPECIAL NEED DECLARATION FORM**

This form is designed to elicit student disability/impairment information so that the University may make all possible provisions to help facilitate the teaching and learning requirement. **All information provided here will be treated as Confidential as per the University Confidentiality policy and Equal Opportunity Policy.**

It will however, with your consent, be made available only to those staff who are directly involved in providing you with the services such as the students’ affair office, the Branch Health Care/counseling services in charge and your Tutor. In case of an emergency, the person authorized by you (family /doctor) may also be contacted by AOU.

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| --- | --- |
| **1.STUDENT PERSONAL INFORMATION** | |
| Branch |  |
| Name |  |
| Student ID |  |
| Telephone No |  |
| E-Mail address |  |
| Academic Year |  |
| Academic Programme |  |
| Academic Semester |  |
| Faculty Name: |  |

|  |  |
| --- | --- |
| **2. DISABILTY TYPE** | |
| Visually Impaired | Completely Blind  Partially Vision impaired |
| Hearing Impaired | Fully Impaired  Partially Impaired |
| Speech Impaired | Mute  Partially unclear speech |
| Long standing illness or health condition (including Heart Disease, cancer, MS,Epilepsy. etc) | Chronic health conditions e.g,  Cancer  Kidney impairment  Heart Disease  Diabetes  Chronic Lung Disease  Rheumatoid Arthritis  Any other |
| Social communication impairment as Asperger’s, Autism spectrum disorder |  |
| Learning Disability | Dyslexia  Dyspraxia  AD(H) D |
| Mental Health Condition | Depression  Bi-Polar disorder  Anxiety Disorders  Schizophrenia  Any other |
| Physical Impairment (impaired mobility) |  |
| Medical Condition not listed above | Please specify: |

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| --- |
| **3. ACCOMMODATION/SUPPORT REQUIRED (PLEASE TICK)** |
| Brail |
| Wheelchair |
| Supported railing bars in ramps and restrooms |
| Counselor/career assistance |
| Any other (please specify) |

|  |  |
| --- | --- |
| **4. DETAILS OF THE AUTHORIZED PERSON** | |
| Name of the authorized person |  |
| Relationship |  |
| Phone Number |  |

**5. If you have any other information that you feel may be relevant to us in providing you with the necessary support. Please do furnish the same here.**

**In order to support you with your requirements, please** **provide evidence of your disability, physical health, or mental health related issue. We require original copies of your evidence, and where necessary.**

I hereby consent to disclosing my disability status to those directly involved in providing me with the services and hereby I declare that all information provided here is true to my best knowledge.

Signature: ………………………………………………………………..

Date: …………………………………………………………………….