Disability Services

APPLICATION TO RECEIVE ACCOMMODATIONS

Please respond to all questions

Background Information

Name _____ D.O.B._____ M ____ F ____

Address: _____

_____

Local address if different from above _____

Phone _____ Cell Phone _____

Name of Parent/Guardian (If Appropriate) _____

Are you affiliated with a Sponsoring Agency? Yes____ No ____

If yes: Voc. Rehab. ____ Easter Seals____ AIB ____ Other _____

Diagnostic Information

State Diagnosed Disability: _____

How does disability impact daily functioning? _____

Identify Functioning Limitation: Major _____

- ☐ A. Sitting
- ☐ B. Talking
- ☐ C. Hearing
- ☐ D. Breathing
- ☐ E. Seeing
- ☐ F. Reading
- ☐ G. Written Expression
- ☐ H. Calculating
- ☐ I. Listening
- ☐ J. Concentrating

Other: _____

Please describe previous support services or accommodations that you received in the past.

A. Accommodations:

B. Adaptive Equipment:

Contact Information

Student #: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

Email Address: _____