

APPLICATION FOR DISABILITY SERVICES

Name: _____ Today's Date: _____

Student ID: _____ or SSN: XXX-XX- _____ Date of Birth: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____

E-Mail Address: _____

Are you a consumer of Opportunities for Ohioans with Disabilities? Yes No

If yes, counselor's name: _____

Counselor's location: City: _____ Email: _____

Where did you attend high-school? _____

Did you receive intervention services in high-school? Yes No

Did you transfer from another college or university? Yes No

What semester do you plan to enter Edison State? Fall Spring Summer Year _____

What is your major or intended major? _____

Current Employer: _____ Since _____

Full-time Part-time: (_____ hours worked per week)

Transportation: Self Family member/ Friend Public transportation

Please mark **ALL** that apply: I am requesting accommodations because I am an individual with:

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Other Psychological Impairment |
| <input type="checkbox"/> Deafness | <input type="checkbox"/> Physical/Medical Impairment |
| <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Traumatic Brain Injury/Closed Head |
| <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Other: _____ | |

*** PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM ***

Using your own words, please describe your disability(ies) and how it affects your ability to function on a college campus.

Please list any medications you are taking or therapies you are receiving and how they may affect your college performance.

If applicable, please list any adaptive/computer technologies you will be using.

Please list the academic accommodations and services you are requesting.

I understand that:

- I may be required to submit documentation of my disability;*
- I must meet the essential requirement of each course I take, with or without accommodations;*
- application to Edison State Community College and selective admission programs are separate processes.*

Signature: _____ Date: _____

PLEASE RETURN THIS FORM TO:
Coordinator of Disability Services
Edison State Community College
1973 Edison Drive
Piqua, OH 45356
Or Fax to (937) 778-4692

OFFICE USE ONLY: Rec'd _____ AA date _____ PHIN date _____ Record ___ File ___ SelfID ___