

**For Office Use Only**

<b>Disabilities:</b> ADD/ADHD	DD	MAN	SPE	WC Access
AUT	DF/HH	MOB	STI	E.R.
BL	LD	PSY	TBI	Emer List
CI	LV	SD	Other	MIL

## ACCESSABILITY SERVICES IN-TAKE FORM

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

Campus Email \_\_\_\_\_ Other Email \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Send Mail To My \_\_\_\_\_ Home Address or \_\_\_\_\_ Campus Address \_\_\_\_\_  
Dorm/Room

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Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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Class Status \_\_\_ Prospective \_\_\_ Transfer \_\_\_ Non-Matriculated \_\_\_ Freshman  
\_\_\_ Sophomore \_\_\_ Junior \_\_\_ Senior \_\_\_ Graduate

Major \_\_\_\_\_ Student ID# \_\_\_\_\_

Academic Advisor \_\_\_\_\_

My Disability/ies \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Academic difficulties I experience  
\_\_\_\_\_  
\_\_\_\_\_

Accommodations I received in the past  
\_\_\_\_\_  
\_\_\_\_\_

Assistive devices I use  
\_\_\_\_\_  
\_\_\_\_\_

Medications/Treatments I Currently Receive

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Please choose one of following categories to represent your ethnicity:

Hispanic, Latino or Latina                       Not Hispanic, Latino or Latina

Please choose one or more of the following categories to represent your racial identity:

American Indian or Alaska Native                       Asian  
 Black or African American                                       White  
 Native Hawaiian or Other Pacific Island

**AUTHORIZATION TO VERBALLY DISCLOSE DISABILITY INFORMATION**

I voluntarily authorize AccessAbility Services at Western Connecticut State University to **verbally** disclose information about my disability to Western Connecticut State University faculty and personnel involved in providing academic or other services to me **only** if my application is accepted by AccessAbility Services and **only** for the purpose of discussing my education or other services pertaining to me at Western Connecticut State University.

I understand that authorization is voluntary, and **if** I authorize the above verbal disclosure, **I may revoke this authorization at any time by written notification to the Director of Disability Services.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

INFORMATION BELOW TO BE COMPLETED BY ACCESSABILITY SERVICES	
Date application received _____	Documentation _____
Documentation approved Y/N _____	If no, reason _____
Reviewed By _____	Date _____
Interview Y/N Date _____	Signature _____
	Date _____