



ACCESSIBILITY SERVICES OFFICE

STUDENT INTAKE FORM

Name _____ Banner ID# _____

Mailing address: _____

City: _____ State: _____ Zip Code: _____

Home phone: _____ Work/cell phone: _____

E-mail address: _____

Emergency contact: _____ Phone #: _____

Disability Information

- | | | |
|--------------------------|------------------------------|------------------------|
| _____ LD/ADD/ADHD | _____ Visual/Blindness | _____ Chronic Medical |
| _____ Hearing Impairment | _____ Traumatic Brain Injury | _____ Temporary Injury |
| _____ Physical | _____ Psychological | _____ Other: _____ |

Please describe your disability and how it affects your academic activities and also your daily living:

Please describe any secondary disability or any additional information that may help us assist you:

Additional Support Agencies

Are you working with any of the following? Please check any that apply.

- | | | |
|-------------------------------|----------------------|------------|
| _____ BVR | _____ Workman's Comp | _____ None |
| _____ Veterans Administration | _____ Other _____ | |

If you checked one of the above, what is your counselor's name? _____

OVER

