



Disability Services Intake Form

PLEASE PRINT

Name: _____ **Date:** _____

Date of Birth: _____ **SSN:** _____ **or EMPLID:** _____

Mailing Address:

Street and Number _____ City _____ State _____ Zip Code _____

E-mail: _____

Telephone: Day _____ Evening _____ Other _____

Currently attending ESCC: Yes _____ No _____

Do you plan to transfer? Yes _____ No _____ Where? _____

Employment:

Currently Employed: Yes _____ No _____ If yes, hours per week: _____

Type of Work: _____

Educational Goals:

- ____ Take a few courses that interest me
- ____ Complete a certificate at ESCC
- ____ Complete a 2-year applied science degree at ESCC
- ____ Complete a 2-year transfer degree at ESCC and transfer to a four-year college
- ____ Take transfer classes and transfer after one year
- ____ Improve basic skills in reading, writing, math, etc.
- ____ Other _____

If seeking a certificate or degree, what is your major? _____

What job or career fields are you considering: _____

Special Interests or Hobbies: _____

Have you registered to vote: Yes _____ No _____

Disability Information: Check all that apply

- | | |
|-------------------------------|---------------------------|
| _____ Blind/Visually Impaired | _____ Cerebral Palsy |
| _____ Deaf or Hard of Hearing | _____ Learning Disability |
| _____ Mobility Impairment | _____ Speech Impairment |
| _____ Brain Injury | _____ Other _____ |

Please describe below how your disability impacts your educational progress:

Please circle any services or accommodations listed below that you received in high school or college.

Services:

Speech therapy
Vision training or prism lenses
Certification for books on tape
Large print textbooks
Braille textbooks
Medication for ADHD
Psychotherapy
Sign language interpreter
Personal assistant

Accommodations:

Use of tape recorder
Extended time on tests or assignments
Provision of private testing room
Special seating arrangement
Special chair or desk/table requirements
Special lighting
Adaptive technology
Other

Are you a client with any Virginia State Agency?

(DRS, DBVI, VDDHH, Mental Health) Yes _____ No _____

Please list: _____

Name of caseworker or counselor:

The ESCC Disabilities Coordinator has my written permission to discuss my accommodations, as necessary, with ESCC faculty and other appropriate college professionals, as necessary. A separate "Release of Information Form" must be obtained to discuss my accommodations with any agency, office, department or other service provider including a counselor, caseworker, physician, or psychiatrist.

Student Signature: _____

Date: _____