



SAN DIEGO COMMUNITY COLLEGE DISTRICT
Disability Support Programs and Services

Application for Services

TODAY'S DATE: _____

Last Name: _____ First Name: _____ MI: _____
Address: _____ City, State and Zip: _____
Student ID#: _____ DOB: _____ Daytime Phone: _____
E-mail Address: _____ Other Phone: _____

GENERAL INFORMATION

Have you applied to SDCCD (Admissions)? Yes ___ No ___

Have you taken the Placement Tests?

MATH: Yes / No; ENGLISH: Yes / No; ESL: Yes / No; DEAF ENGLISH: Yes / No

Would you like assistance with Voter Registration? Yes ___ No ___

Have you ever received services from any SDCCD DSPS Office? Yes / No Year ___ Site ___

Emergency Contact Person: _____

Relationship to Student: _____ Phone: _____

Who referred you to our program? _____

Are you a client of a rehabilitation agency? ___ No ___ Yes

Please identify: Counselor's Name _____ Phone # _____

Are you receiving services through?

___ EOPS ___ Cal WORKS ___ WorkAbility III ___ Financial Aid ___ SSI/SSDI

___ Other _____

Have you ever been convicted of a felony? ___ Yes ___ No

Incarcerated? ___ Yes ___ No Parole Officer: _____

What is the highest level of education completed? (Circle all that apply)

8 9 10 11 12 HS diploma Cert. of Completion GED AA BA MA

Graduation Date: _____

High School / other schools attended: _____

Was student ever in Special Ed./Resource/Remedial classes? ___ Yes ___ No

Are you currently working? ___ Yes ___ No

If yes, please describe current employment:

Where? _____

Number of hours per week? _____

Can you be contacted at work? ___ Yes ___ No Phone #: _____



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DISABILITY INFORMATION
Please respond to all

Do You Have:	Yes	No	Do You Have:	Yes	No
Acquired Brain Injury			Visual Impairment		
Unconscious due to illness			Blind		
Sustained head injury			Contact lenses or glasses		
Seizures			Eye Exam past two (2) years		
Hearing Impairment			Learning Disability (LD)		
Deaf			Requesting first time LD testing		
Hard-of-hearing			LD has been verified by a:		
Frequent ear infections			High School		
Hearing aid			University		
Hearing exam in past five (5) years			CA Community College		
Use Sign Language					
Mobility			Psychological Disability		
Amputation			History of mental health problems		
Arthritis			Hospitalized for mental health reasons		
Cardiovascular			Treated as an outpatient		
Cerebral Palsy			Participated in mental health counseling		
Gastrointestinal Disorder			History of Substance Abuse		
Immune System Disorder			Hospitalized for substance abuse		
Multiple Sclerosis			Treated as out patient		
Orthopedic			Participated in counseling for S.A.		
Post Polio			How long maintained sobriety _____		
Respiratory					
Other: _____			Other Disabilities		
			Aids / HIV		
Developmentally Delayed Learner			Attention Deficit Disorder (ADD or ADHD)		
			Autism / Asperger Syndrome		
			Cystic Fibrosis		
			Difficulty Concentrating		
			Diabetes		
			Environmental Sensitivity		
			Epilepsy		
			Hemophilia		
			Neurological Exams (CT, MRI, etc.)		
			Taking Medications		
			Other Health: _____		

Verifying Professional Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ FAX number: _____

It is the responsibility of the student seeking accommodation and service to provide a comprehensive evaluation verifying the disabling condition and the resultant limitations.

Student Signature _____ Date _____