



Clackamas Community College
Disability Resource Center
19600 S. Molalla Ave.
Oregon City, OR 97045
(503) 657-6958 x 2324

APPLICATION REQUEST FOR SUPPORT SERVICES

Name: \_\_\_\_\_ Date: \_\_\_\_\_
Address: \_\_\_\_\_ ID #: \_\_\_\_\_
Phone: \_\_\_\_\_
Cell: \_\_\_\_\_
E-Mail: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Nature of Disability: \_\_\_\_\_

Medications: \_\_\_\_\_

New or Returning Student: \_\_\_\_\_

Career/Educational Goals: \_\_\_\_\_

Are you working with Vocational Rehabilitation or other such agency? \_\_\_\_\_

If yes, who is your counselor and what branch are they at? \_\_\_\_\_

Are you in the Occupational Skills Training program? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_
(This information is confidential and will be used only to help determine and grant needed support services)

SUPPORT SERVICES POSSIBLY NEEDED

- Campus Orientation
Note Takers
Reader
Sign Language interpreters
Enlarged-print Materials:
Other - Please specify:
Books on Tape
Tape Recorders
Writer
Extra Time on Tests
Distraction Free Testing

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_