ESSEX COUNTY COLLEGE STUDENTS FIRST

Office of Student Development and Counseling
Disability Services

REQUEST FOR ACCOMMODATIONS APPLICATION

Semester: Fall 20_____ Spring 20_____ Summer 20 _____

Personal Information (Please Print)

Name: _____Sex: _____ Date of Birth: ____/____/_____

Permanent Address: _____
Number Street

_____
City State Zip Code

Telephone: _____Cell Phone: _____ E-mail: _____

High School: _____Date of HS Graduation: _____

Academic History

College Major: _____ College Identification Number: _____

If College ID# Number is not known, please provide: Last four Numbers of Social Security Number: _____

Are you receiving financial aid? Yes: ___ No: ___ Are you attending full-time? Yes: _____ No: _____

Disability Information: For which diagnosed disability are you requesting accommodations?

____ Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD)
____ Blind/ Visual Impairment
____ Cognitive Impairment
____ Deaf/ Hard of Hearing
____ Health Impairment (Chronic Illness)
____ Learning Disability (LD/SLD/MLD)
____ Mental Health/ Psychological/ Psychiatric Impairment
____ Mobility/ Physical Impairment
____ Multiple Disability
____ Speech Impairment
____ Other Impairment _____

When was your disability first identified or diagnosed? _____

Have you received disability accommodations in the past? (Y/N _____) If yes where? ____ Elementary School ____ Middle School ____ High School ____Community College ____ Four Year University/ College

Please describe previous accommodations: _____

_____

_____

_____

_____

What learning accommodations do you believe you need to be successful at this college? Permission to use your: Computer: ____ Calculator: ____ Tape Recorder: ____ Extended Time for Testing/Assignments: ____ Visual Supplements/ Power Point: _____ Kurzweil Software: ____ *Visual/Hearing Impaired Students Only- Note Taker/ Interpreter: _____ Adaptive Texts: _____

Other: _____

In what academic areas do you think you will need the most help? _____

Have you ever used any forms of adaptive technology (i.e., recorded books, reading machines or other text software or equipment)? Yes: _____ No: _____ If yes, what kind? _____

Are currently working with any outside professionals? Yes: ____ No: ____ If yes, please complete the following:

Name of Professional: _____Title: _____

Address: _____Phone#: _____

Please list any medication(s) you are taking that might affect your performance as a student:

_____

Are you working with any agencies? Yes: _____ No: _____ If yes, please complete the following:

Name of outside agency_____

Name of contact person: _____Phone#: _____

By completing and submitting this application, I am officially applying for services from Student Disability Services. I confirm that all information provided in this application is factual, complete and accurate.

I am giving permission to Disability Services to:

1. Obtain further information from the Child Study Team or professional, if necessary,
2. List my name as a student being serviced by Disability Services for administrative purposes only, if I am accepted into the program, and
3. Provide referrals to outside agencies when necessary

_____ _____

Signature Date

_____ _____

Signature (Parent/Guardian if applicant is under 18 years old) Date

Mail to: Essex County College, *Attention: Disability Services*, Room 4122-I,
303 University Ave., Newark, New Jersey 07102.
Please email the office at disability@essex.edu, mercado@essex.edu or call 973-877-3071 for an appointment.