

SERVICE REQUEST FORM

Semester _____ 20____

Date Submitted ____ / ____ / 20____

Name (Print) _____ Last, _____ First _____ Student ID Number or Birthdate _____

Mailing Address _____, HI _____
City _____ Zip Code _____

Phone Number _____ Email _____

DVR/Agency Counselor: _____ Phone Number: _____

Major: _____

I. Disability Information

Primary _____
Secondary _____
Other _____

Are you currently or have previously received therapy for your condition(s)? Yes No

If yes, when and with who _____

Are you currently or have previously been on any medication(s) for your conditions? Yes No

If yes, type/frequency _____

II. Impact of Disability - How does your condition(s) impact your ability to (check all that applies):

- | | | |
|---|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Listen | <input type="checkbox"/> Take Notes | <input type="checkbox"/> Speak |
| <input type="checkbox"/> Comprehend | <input type="checkbox"/> Concentrate | <input type="checkbox"/> Memorize |
| <input type="checkbox"/> Socialize | <input type="checkbox"/> Manage self | <input type="checkbox"/> Focus |
| <input type="checkbox"/> Other -please list | | |

Supports you believe could help you (check all that apply):

- | | | |
|---|--|---|
| <input type="checkbox"/> Notetaker | <input type="checkbox"/> Extended time on test | <input type="checkbox"/> Quiet testing room (314/315) |
| <input type="checkbox"/> Reader/Scribe | <input type="checkbox"/> Registration Assistance | <input type="checkbox"/> Alternative format books |
| <input type="checkbox"/> Unscheduled Breaks | <input type="checkbox"/> Priority Seating | <input type="checkbox"/> Sign-Language Interpreters |
| <input type="checkbox"/> Assistive Technology | <input type="checkbox"/> Consultation with Faculty | <input type="checkbox"/> Emergency Evacuation |

III. Personal History - Please Describe your experiences with:

How your disability has created barriers for you in the past:

Accommodations or support services you have received in education and/or in employment:

Skills and or strategies you have developed to adjust to your condition(s):

IV. Educational History/Background

What high school did you graduate from? _____

Did you participate in Special Education? Yes No

Did attend college before? Yes No

If yes, where and estimated GPA _____

What kind of challenges did you encounter in high school and/or college?

Did you receive academic accommodations in high school and/or at college? Yes No

If yes, please describe what they were:

What is your career plan/goal?

V. Other

Have you ever been employed? Yes No

If yes, where and when: _____

Do you need to be a full time student? Yes No