



Accessibility Service Student Intake Form

STUDENT NAME: (Top portion must be completed in its entirety).

(Last Name) (First Name) (Middle Name)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____

E-mail Address: _____

DISABILITY INFORMATION:

- | | | |
|---|---|---|
| <input type="checkbox"/> LD/ADD/ADHD | <input type="checkbox"/> Visual/Impairment | <input type="checkbox"/> Temporary Injury |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Traumatic Brain Injury | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Psychological Disability | |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Learning Disability | |

Please describe your disability and how it affects your **academic activities** and **daily living**:

Type of accommodation requested: _____

Please describe any **secondary disability** or **additional information** that may help us assist you including type of accommodations received in the past.

List any medications: _____

ADDITIONAL SUPPORT AGENCIES:

- | | | |
|--|---|-------------------------------|
| <input type="checkbox"/> BVR | <input type="checkbox"/> Workman's Compensation | <input type="checkbox"/> None |
| <input type="checkbox"/> Veterans Administration | <input type="checkbox"/> Other _____ | |

If you checked one of the above, what is your counselor's name? _____



When do you plan to enroll at Trinity College of Nursing & Health Sciences? _____

Please read the following statement before signing and returning this form. If you have any questions, please contact Bobbi Biringner at (309) 779-7720.

I understand that in addition to completing this form, I need to provide documentation to develop an accommodation plan to receive services. As a participant in the Accessibility Services program at Trinity College of Nursing & Health Sciences, I give permission to share information with other college departments and faculty that will support and enhance the services I am requesting through this program.

Student Signature: _____ Date: _____

Please return this form to the following:

Mail: **Bobbi Biringner**
Trinity College of Nursing & Health Sciences
2122 25th Avenue
Rock Island, IL 61201-5317

FAX: **309-779-7748**
DROP OFF: **Student Services Office**

Consent to Release Information

While the Dean of Enrollment Management will not release specific information about a disability, he/she will verify that the appropriate disability documentation is on file and share with the faculty/staff the reasonable accommodations.

I authorize the Dean of Enrollment Management to share, as needed, more specific detailed information regarding my disability with Trinity College of Nursing & Health Sciences personnel who have a legitimate need to know in order to provide appropriate accommodations.

This may include: **Faculty, Academic Advisors, Dean of Nursing & Health Sciences, Program Coordinators, College Administrators**, or others whose response to my request for accommodations may require knowledge regarding my disability.

Initial: _____

I authorize the Dean of Enrollment Management to discuss my disability, accommodations, and general progress with:

Parents or Guardians (list names): _____

Initial: _____

Community Agency/Persons: _____

Initial: _____

