IVC DISABLED STUDENTS PROGRAM & SERVICES APPLICATION

Student ID#:_____ **Social Security#:** _____-_____-_____

Name:_____ **Sex: M**____ **F**____
First Last

Address: _____ **Phone# (**____**)**_____
Number and Street

_____ **Birthdate:**_____
City State Zip Code

Email Address:_____

ARE YOU A STATE DEPARTMENT OF REHABILITATION (D.O.R.) CLIENT? _____**YES** _____**NO**

If yes, who is your counselor?_____

In which city is he/she located?_____

What is your vocational goal with Dept. of Rehab?_____

DO YOU GIVE THE DSP&S FACULTY AND STAFF PERMISSION TO SPEAK WITH YOUR PARENT(S)?
_____**YES** _____**NO**

By signing below, I give permission for the DSP&S certificated program staff to discuss my educational situation with other professionals who have a legitimate educational need to know. I also acknowledge that the information listed on this data form is correct and accurate to the best of my knowledge.

Student Signature:_____**Date:**_____

************BELOW FOR OFFICE USE ONLY************

PRIMARY DISABILITY (_____Permanent _____Temporary)

_____ABI _____DDL _____Hearing _____Learning _____Mobility
_____Other Health _____Psychological _____Speech _____Visual

Describe:_____

Medications:_____

Classroom Side Effects:_____

SECONDARY DISABILITY (_____Permanent _____Temporary)

_____ABI _____DDL _____Hearing _____Learning _____Mobility
_____Other Health _____Psychological _____Speech _____Visual

Describe:_____

Medications:_____

Classroom Side Effects:_____

CERTIFICATED SIGNATURE:_____**DATE:**_____

7/07