TRINITY COLLEGE OF NURSING & HEALTH SCIENCES
IOWA HEALTH SYSTEM

Accessibility Services Student Intake Form

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

_____ ID#: _____
(Last Name) (First Name) (Middle Name)

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work/Cell Phone: _____

E-mail Address: _____

Emergency Contact: _____ Phone #: _____

DISABILITY INFORMATION:

- ☐ LD/ADD/ADHD
- ☐ Hearing Impairment
- ☐ Physical
- ☐ Visual/Blindness
- ☐ Traumatic Brain Injury
- ☐ Psychological
- ☐ Chronic Medical
- ☐ Temporary Injury
- ☐ Other: _____

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

_____

_____

_____

Please describe any **secondary disability** or **additional information** that may help us assist you:

_____

_____

_____

ADDITIONAL SUPPORT AGENCIES:

- ☐ BVR
- ☐ Veterans Administration
- ☐ Workman's Compensation
- ☐ Other _____
- ☐ None

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 Lenore Knock 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. I also need to complete the College's Admissions Process, which is separate from these procedures.

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

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

FOR EMPLOYEE USE ONLY

Employee Initials: _____ Date: _____

Employee Notes:

_____

_____

_____

_____

_____

_____

_____

☐ Documentation Received Date: _____

TRINITY COLLEGE OF NURSING & HEALTH SCIENCES
IOWA HEALTH SYSTEM

Accessibility Services Auxilary Aides & Academic Accomodations Form

STUDENT NAME:

ACADEMIC PROGRAM:

Student Signature: _____ Date: _____

Director of Student Services Signature: _____ Date: _____