ACCESSIBILITY/DISABILITY SERVICES
REQUEST FOR ACCOMMODATIONS FORM

1325 N. College Avenue, Claremont, CA. 91711• Ph. (909) 447-2507

Please submit completed form to the Accessibility/Disability Services Office

Today's Date: ____________

STUDENT INFORMATION

Name: ________________________________ Email: ____________________@cst.edu

Phone: (Home)______________________________________(Cell) ______________________________________

Date of Birth: __________________________

ACADEMIC INFORMATION

Enrollment Date: _______________________________ Degree Program ________________________________

Advisor: ____

Anticipated Graduation Date:_______________________________

MEDICAL INFORMATION

Disability Diagnosis: ____

Disability is: ☐ Permanent ☐ Temporary

If temporary, please explain:

Functional/Educational Limitations:

NATURE OF DISABILITY

What is the nature of your disability(ies)? (Check all that apply)

☐ Learning Disability
☐ Attention Deficit/Hyperactivity Disorder
☐ Chronic Health Disorder
☐ Psychological Impairment
☐ Visual Impairment
☐ Hearing Impairment
☐ Mobility Impairment
☐ Other(explain below)

ACCOMMODATION HISTORY (i.e. undergrad, employment or previous graduate work):

ACCOMMODATIONS REQUESTED

KIN-RELATED EXCEPTION REQUEST

- The above information is strictly confidential, and will only be discussed as is necessary to insure the appropriate accommodations for each student.
- Student files will be retained for five years after graduation or the last date of attendance. Incomplete files will be kept for one year from the original of intake.

Student Signature: ______________________________Date:__________

Access.|Dis. Coordinator Signature:____________________Date:__________

(10.21.22)