

APPENDIX A
Application for Disability Support Services

DATE SUBMITTED TO DSS OFFICE: _____

Name: _____ Student ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: (____) _____ Alternate Phone: (____) _____

Student email address*: _____

Program of Study: _____

Explain your disability and current treatment: _____

What accommodations are you requesting**? _____

DSS Staff will communicate with you predominately through your student e-mail, so please be in the practice of checking it often.

** A history of accommodations in itself does not warrant the provision of similar accommodations at Wallace Community College.**

*****Information to be provided by a qualified health professional and attached to this application:**

1. Include a statement of the specific diagnosis of the disability.
2. Describe the applicant's functional limitations due to the disability, and the impact of those limitations on physical, perceptual and cognitive abilities.
3. Recommend specific accommodation(s) and for each accommodation, provide a rationale as to how it will reduce the impact of the functional limitation(s).
4. Health professional should state his/her professional credentials, training, work experience and any licenses he/she holds that support his/her qualifications to diagnose and/or treat applicant's disabilities.

****Once you make application for services and provide the appropriate documentation, the DSS Coordinator will review your paperwork and inform you of the accommodations you may receive.****
