APPLICATION FOR MAC ACCESS OFFICE
DISABILITY SUPPORT SERVICES

NAME:_____ HOME PHONE: _____

STUDENT ID: _____ WORK PHONE: _____

STREET ADDRESS: _____ E-MAIL: _____

CITY/STATE/ZIP: _____

BIRTH DATE: _____

BACKGROUND INFORMATION:

HIGH SCHOOL ATTENDED: _____ GRADUATION DATE:_____
HAVE YOU ATTENDED M.A.C. IN THE PAST? IF SO, WHEN?_____
HAVE YOU ATTENDED ANOTHER COLLEGE OR UNIVERSITY? IF SO, WHERE?
_____

WHEN WILL SERVICES NEED TO BEGIN?

__ FALL __ SPRING __ SUMMER YEAR BEGIN _____

HOW ARE YOU PAYING FOR COLLEGE?

___ SELF/PARENTS
___ VOCATIONAL REHABILITATION
___ REHABILITATION SERVICES FOR THE BLIND
___ PELL GRANT
___ VETERANS BENEFITS
___ A+
___ OTHER:_____

CHECK ALL THAT APPLY:

ACCOMMODATIONS ARE BASED ON SUPPORTED DOCUMENTATION OF THE FOLLOWING:

___ ACQUIRED BRAIN INJURY
___ ADD/ADHD
___ ASPERGER SYNDROME
___ BLIND
___ LOW VISION
___ DEAF
___ DEAF/BLIND
___ DEVELOPMENTAL DISABILITY
___ EMOTIONAL DISABILITY
___ HARD OF HEARING
___ LEARNING DISABILITIES
___ NEUROLOGICAL DISABILITY
___ ORTHOPEDIC DISABILITY
___ OTHER DISABILITY _____

IF APPLICABLE, LIST ANY COLLEGE ACCOMMODATIONS USED IN THE PAST:

_____

STUDENT SIGNATURE: _____ DATE: _____

INFORMATION REGARDING DISABLITY IS KEPT PRIVATE.
ONLY INFORMATION NECESSARY TO ASSURE THE EFFECTIVE IMPLEMENTATION OF ASSIGNED ACCOMMODATIONS WILL BE SHARED WITH FACULTY.

FORM AVAILABLE IN ALTERNATE FORMAT UPON REQUEST.