



# WESTMONT

## Office of Disability Services Student Intake Form

Please submit the appropriate disability verification with this form. See guidelines for documentation on our website at <http://www.westmont.edu/offices/disability/>.

**PERSONAL INFORMATION:** (Please print clearly or attach typed document) Date \_\_\_\_\_

NAME: _____	EMAIL: _____
ADDRESS: _____	CELL: _____
_____	Westmont I.D. _____
CITY _____ STATE _____	Dorm _____
BIRTH DATE _____	EMERGENCY CONTACT PHONE _____

**Academic status**

First Year \_\_\_\_\_ Second Year \_\_\_\_\_ Third Year \_\_\_\_\_ Fourth Year \_\_\_\_\_ Other \_\_\_\_\_  
 Major program (if declared) \_\_\_\_\_

The documentation I will submit verifies that I have the following disability: (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> LEARNING DISABILITY                       | <input type="checkbox"/> LEARNING AND MEMORY PROBLEMS DUE TO BRAIN INJURY |
| <input type="checkbox"/> ATTENTION DEFICIT HYPER ACTIVITY DISORDER | <input type="checkbox"/> DEAFNESS   |
| <input type="checkbox"/> PSYCHOLOGICAL DISABILITY                  | <input type="checkbox"/> HARD OF HEARING                                  |
| <input type="checkbox"/> AUTISM/PERVASIVE DEVELOPMENTAL DISORDER   | <input type="checkbox"/> BLINDNESS  |
| <input type="checkbox"/> MOBILITY IMPAIRMENT                       | <input type="checkbox"/> OTHER _____                                      |
| <input type="checkbox"/> LOW VISION/VISUAL IMPAIRMENT              |   |
| <input type="checkbox"/> CHRONIC HEALTH IMPAIRMENT                 |   |

2. Please briefly describe your understanding of your current impairment and any relevant diagnosis.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. When were you first diagnosed with the condition you consider disabling? If more than one, list them separately.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

4. Describe how your impairment(s) impact(s) your functioning.

---

---

---

---

---

---

---

---

5. What accommodations are you requesting at Westmont College?

---

---

---

---

---

6. Describe in detail the accommodations you have received in the past, including the nature of the accommodation(s), the name of the providing institutions, and dates provided.

---

---

---

---

7. When and by whom were you recently evaluated/treated for the condition(s) that cause your impairment?

---

---

---

---

Thank you for your cooperation. You will find specific information on our website, <http://www.westmont.edu/offices/disability/index.html>, about the type of documentation necessary for each type of impairment. If you have any questions, please contact us directly at 805-565-6135 OR 805-565-6186.

A review of your documentation relating to your request will not be commenced until this form and all supporting documentation have been received. We do not review materials until your file is complete. Upon receipt of all documentation, your file will be reviewed, a process that typically takes no less than 14 days. **Please do not send original copies of documentation. We do not return materials once submitted.**

By signing below, you are initiating your request to be established as a student with a disability in accordance with federal and state regulations.

Signature of Student \_\_\_\_\_ Date \_\_\_\_\_

**Email, fax or mail forms to: Office of Disability Services, Westmont College, 955 La Paz Rd, Santa Barbara, CA. 93108 Attn: Sheri Noble. [snoble@westmont.edu](mailto:snoble@westmont.edu) FAX 805-565-7244**

OFFICE USE ONLY

DATE INTAKE FORM REC'D \_\_\_\_\_

DOCS COMPLETE YES \_\_\_\_\_ NO \_\_\_\_\_

DS VERIFICATION \_\_\_\_\_

CONFIDENTIALITY AGREEMENT \_\_\_\_\_

OTHER \_\_\_\_\_