



In case of emergency, whom may we contact on your behalf?

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

(Street & Apt. #)

(City)

(State)

(Zip)

Relationship: \_\_\_\_\_

*% , QWHQVLYH (QJOLVK 3VWXGDIQW, V3SOHDVH FKHFN WKLV ER[  
DQG PRYH WR 6HFWLRQ , , ,*

6HFWLRQ , , (GXFDWLRQ , QIRUPDWLRQ

6FKRRO

Major / Program: , QFOXGH \*UDGXDWH RU 8QGHIJUDGXDWH \_\_\_\_\_

First Semester at IIT: \_\_\_\_\_

Anticipated Graduation Date: \_\_\_\_\_

Please briefly describe your program. Be sure to include information about fieldwork, clinical or laboratory components, comprehensive examinations, a thesis/dissertation, or other requirements that may impact your disability or need for accommodations: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Section III: Disability Related Information**

Please answer the following questions regarding your disability and how it impacts your ability to learn, attend, or participate in university life.

**1. Please indicate your disability type(s). Check all that apply:**

- Learning Disability
- Attention Deficit/Hyperactivity Disorder (AD/HD)
- Chronic Medical Condition

Please specify: \_\_\_\_\_

Physical Disability (mobility impairment)

Please specify: \_\_\_\_\_

Psychiatric Disability (psychobgical or mental illness)

Please specify: \_\_\_\_\_

Visual Impairment or Blindness

Deaf or Hard-of-Hearing

Traumatic Brain Injury

Temporary Injury/Condition

Please specify: \_\_\_\_\_

Other

Please specify: \_\_\_\_\_

2. Please check all that apply:

I use a wheelchair.

I use assistive mobility devices (braces, crutches, cane, or prosthesis).

If yes, list all of the medications you are taking: \_\_\_\_\_

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If yes, please also list any side effects of the medications that you are taking and their impact on your academic/cognitive abilities and/or other activities:

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**4. Please check all of the reasonable accommodations that you are requesting:**

Testing Accommodations

Extended time for testing:

Amount Requested: \_\_\_\_\_



Section IV: Agency Information

Do you receive services from any of the following agencies?  Yes  No

Vocational Rehabilitation Services

Specify State and Agency: \_\_\_\_\_

Commission for the Blind & Visually Handicapped (CBVH)

Veterans Administration (VA)

Recordings for the Blind & Dyslexic (RFB&D)

Other: \_\_\_\_\_

If yes, please provide the following information:

Counselor's name: \_\_\_\_\_

Office Address or Location: \_\_\_\_\_

\_\_\_\_\_

Phone #: \_\_\_\_\_ Ext: \_\_\_\_\_

Services currently receiving from agency: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Send Form To:

IIT Center for Disability Resources

10 W. 35th Street, Third Floor

Chicago, Illinois 60616

( P D I ) Disabilities@iit.edu

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