AUSTIN COMMUNITY COLLEGE DISTRICT

Office for Students with Disabilities

Application for Services

Name: ______________________________ SSN / ID #: ______________

Address: ______________________________ DOB: ______________

City: ______________ State: ________ Zip: ________ Ph # (hm): ______________

Email Address: ______________________________ Ph # (cell): ______________

Major/Interest: ______________________________

Disability Description: ______________________________

Current Treating Professional: ______________________ Phone: ______________

Therapist/Psychiatrist (if any): ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

Emergency Contact: ______________________ Phone: ______________

List Support You Receive: ☐ DARS ☐ VA ☐ MHMR ☐ Other ______________

Agency Name: ______________ Contact: ______________ Phone: ______________

Agency Name: ______________ Contact: ______________ Phone: ______________

I understand that I must meet with the Coordinator of the Office for Students with Disabilities and provide documentation of my disability in order to be eligible to receive accommodations. I certify that the above information is accurate and true to the best of my knowledge. I agree to abide by the college policies and procedures as stated in the Austin Community College Student Handbook and on the OSD website (www.austincc.edu/osd).

Signature: ______________________ **Date:** ______________

FOR OSD PERSONNEL USE ONLY (initial when complete):

☐ EMER ☐ Excel ☐ eDaisy ☐ ECS, ISD: ______________

Please check all that apply:

TSI Complete:	☐ R	☐ W	☐ M
TSI Not Complete:	☐ R	☐ W	☐ M
TSI Waived/Exempt:	☐ R	☐ W	☐ M