TECHNICAL COLLEGE OF THE LOWCOUNTRY

TCL Student Disability Services Intake Form

Date: _____ **Student I.D. #:** _____

Name: _____
(Last) (First) (MI)

Permanent Address: _____
Street/Route City State Zip

Mailing Address: _____

Phone #: _____ Emergency Phone #: _____

E-mail Address: _____

Major: _____ College Entry Semester: _____

1st Semester Requesting Services: _____

Identification: Who referred you to Student Disability Services?

__ Self __ Parents __ High School __ Another College __ Instructor

__ Advisor __ Counselor __ Voc. Rehab. __ Private Counselor __ Other Agency

Disability:

Primary: _____

Other: _____

Initial Diagnosis: ____ K-8th ____ High School ____ College _____ Other

Documentation: Adequate _____ Additional Information Needed _____

Referred to: _____

SDS Staff:
_____