

CSP/DISABILITY SERVICES REGISTRATION FORM

(PLEASE PRINT CLEARLY)

Date: _____ Birth Date: _____

Name: _____ SS# _____

Address: _____ Patron ID# _____

City and State: _____ Zip code: _____

Telephone #: _____ Cell phone #: _____

(If living on or near campus)

Campus Address: _____

Campus Phone: _____

Please describe how your disability affects your education:

Official Name of Disability: _____

What Community disability services are you involved with?

____ ACLD (Tutor's name) _____

____ Vocational Rehab. (Counselor's name) _____

E mail address: _____

Are you registered to vote? Yes _____ No _____

If not, would you like a voter registration form? Yes _____ No _____

DEMOGRAPHIC INFORMATION

DATE: _____

TELEPHONE:

NAME: _____

CELL PHONE:

ADDRESS:

CITY, STATE: _____ ZIP:

S.S. #: _____

PATRON I.D. #:

GRAD: _____ UNDERGRAD: _____

OF HOURS

COMPLETED: _____

COLLEGE ENROLLED: _____

FIRST SEMESTER ATTENDED: _____

REHAB CLIENT: YES NO

DISABILITY: L. M. V. P. H. O.