



2200 BONFORTE BOULEVARD
PUEBLO COLORADO 81001-4901

VOICE: 719 549-2648
FAX: 719 549-2195

Disability Resource & Support Center
Application for Classroom Accommodations

Students requesting classroom accommodations at Colorado State University-Pueblo must complete and return this form to the Disability Resource & Support Center. The information requested is necessary to assist you with appropriate support services at the University.

Date of Application: _____

Applicant Contact Information

Name: _____ PID #: _____

Phone: _____ Alternate Phone: _____

E-Mail Address: _____

Permanent Address: _____

Local Address: _____

Preferred Method of Contact: _____

Emergency Contact Information

Name and Relationship: _____

Phone: _____ Alternate Phone: _____

Disability Information

Have you ever been tested for or diagnosed with a disability? _____

If yes, when: _____

Describe your disability: _____

All information provided on this form will remain confidential.

What support services/accommodations are you seeking from DRSC? _____

Are you currently receiving services through:

Colorado Division of Vocational Rehabilitation: _____

Veterans Vocational Rehabilitation: _____

If yes, please provide your counselor's name, and contact information: _____

Educational Information

Major: _____

Are you a transfer student? _____ Institution: _____

Did you receive support services? _____

If yes, describe the types of services you received: _____

High School Name: _____ Date of Graduation: _____

Did you receive support services in High School? _____

If yes, describe the types of services you received: _____

Demographic Information (Voluntary – mark all that apply)

Gender Identity: Woman Man Other (please identify): _____

Ethnic Origin: Asian International
 Black or African American Native American
 Caucasian Other (please identify): _____
 Hispanic or Latino/a Unknown

Have you, or do you currently, served in the U.S. Armed Forces? Yes No



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Disability Resource & Support Center
INFORMED CONSENT TO RELEASE INFORMATION

I, _____ PID# _____,
hereby authorize the Disability Resource & Support Center to discuss either in writing or orally, my academic accommodations with appropriate administrators, instructors, professors, third-party service providers (medical personnel, diagnosticians, vocational rehabilitation counselors, vendors, etc.), student assistants, and other persons deemed necessary by the Disability Resource & Support Center staff for the purpose of providing and/or coordinating academic services for me with Colorado State University-Pueblo.

I would like to add the following person(s) to this release: _____

With the following restrictions: _____

The consent may be withdrawn at any time except when action has already been taken to comply with this consent.

Student Signature Date

Current Address: _____

Phone: _____ Alternate Phone: _____