Santa Monica College
Center for Students with Disabilities

APPLICATION FOR SUPPORT SERVICES

Initial Date of Application for Services _____Semester_____Year_____
Last Name_____ First name_____ Middle Initial ___
SMC ID# _____ Date of Birth_____ Age____ Gender_____
Street Address_____ City_____ State___ Zip_____
Primary Phone_____ Secondary Phone_____
Email_____
Marital Status_____ Educational Goal_____ Career Goal_____
Major_____

Nature of Disability

Age of Onset___ Medication (optional)_____

Types

Physical Hearing_
Learning_____ Vision_____
Health_____ Acquired Brain Injury_____
Mental Health_____ ADH/ADD_____
Spectrum_____ Other_____

Off Campus Affiliations

1. Are, (or were), you a client of Department of Rehabilitation?_____
   If yes, name of your rehabilitation counselor_____
   Address_____ Phone_____
   E-mail_____ FAX _____
2. Are, (or were), you a client of Regional Center?_____
   If yes, name of your Regional Center Counselor_____
   Address_____ Phone_____
   E-mail_____ FAX _____
3. Are you currently receiving psychological services?_____
   If yes, name of your psychotherapist_____
   Address_____ Phone_____
   E-mail_____ FAX _____

Emergency Contact Person

Name of person to notify in case of an emergency. _____
Relationship to you _____ Phone# _____

Educational History

Highest Grade Completed: _____ Degrees Achieved_____
Please list the last two schools you have attended.

1. Name of School.
   _____City_____State___
   Date Last Attended_____
2. Name of School.
   _____City_____State___
   Date Last Attended_____

Employment History

Name your most recent employer, if applicable._____
Position_____ Dates: From/To_____

I agree that if necessary for medical or educational purposes, or if necessary for the safety of myself, or others, information about me may be released to, or obtained from an instructor, relevant agency, or family member, or the Care and Prevention Team (CPT). I understand that information contained in my file will be available to the California Community College Chancellor's Office if they request it for an audit, a program evaluation, or educational research.

Signature. _____Date _____

Medical/Educational Information Release Form

In order to receive disability-related services at Santa Monica College, a verification of disability must be provided.

Name of Physician or Agency _____

Phone number_____

Street Address_____City_____ State__ Zip Code_____

I hereby request and authorize you to release to Santa Monica College any medical/educational information pertaining to me that you may have, including diagnosis, psychological testing with raw data, Individual Educational Plan (IEP), Vocational Rehabilitation Plan, and relevant medical information. I request that the professional designated above complete this form.

Signature of Student _____ Date of Birth_____

Print Name _____

Signature of Parent or Guardian (if student is under 18 years old)_____

Print Name _____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

The above student has requested support services through our Center for Students with Disabilities at Santa Monica College. To provide such services, we require certain information from you which will become part of the student record, and may be released to the student upon their written request. Please respond to the following questions:

Primary Disability

1. Diagnosis_____

   DSM IV Code (if applicable) _____Date of Onset_____

   Duration of Disability: Permanent _____ or temporary, how long?_____

   Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms	Level of Severity
_____	_____
_____	_____
_____	_____
_____	_____

2. Is this student currently in treatment with you_____

   And if so, when did you last see this student _____

3. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication	Side Effects	Level of Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ License Number:_____ Date: _____

Title: _____+ Phone Number:_____

Secondary Disability (if applicable)

1. Diagnosis _____
2. DSM IV Code (if applicable) _____Date of Onset: _____
3. Duration of Disability: Permanent _____ or temporary, how long?_____
   Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms	Level of Severity
_____	_____
_____	_____
_____	_____
_____	_____

4. Is this student currently in treatment with you_____
   And if so, when did you last see the student? _____
5. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication	Side Effects	Level of Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature _____ License Number:_____ Date: _____
Title: _____+ Phone Number:_____

Please print and mail to address below or scan & email to dsps@smc.edu

Nathalie Laille, M.S., Coordinator
Center for Students with Disabilities
Santa Monica College
1900 Pico Blvd.
Santa Monica, CA 90405
Phone: 310-434-4265

DSP&S Release of Information:
The Santa Monica Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Center for Students with Disabilities Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of regulations, Title 5, Section 56000 et seq.
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FOR OFFICE USE ONLY Date Medical Info Requested_____2nd Request_____