

Office for Students with Disabilities & Deaf Services
DON 147
303 Homestead Ave
Holyoke MA 01040
P: 413.552.2417
VP: 413.650.5502
F: 413.552.2058

Date: _____

Student Information Form

Name

Last

(Preferred) First

Middle

Student ID#

Birth Date: / /

Mailing Address:

Street

City

State

Zip

Primary Phone: ()

Alt. Phone: ()

Preferred Email:

Name of High School: _____ Date of Graduation: _____

Did you receive any accommodations in High School? Yes No

If yes, what accommodations were beneficial to you? _____

Did you take and pass the MCAS? Yes No

If you have not completed High School, did you earn a GED or HiSET (High School equivalency)?

Yes Year: _____ No

Are there any medical issues, which you believe OSDDS staff should be aware of?

Yes No

If yes, please list: _____

Date of Admission at HCC: _____ Program of Study: _____

Disability: _____

Did you bring any documentation today? Yes No

Please briefly explain what brings you to the OSDDS office currently _____

OFFICE USE ONLY