



One College Drive, Calais, Maine 04619

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Application for Accessibility Services

Date: _____

Name _____ Date of Birth _____

Mailing Address _____

Phone: Home _____ Cell _____ email: _____

Check all that apply:

___ Hearing Impairment

___ Visual Impairment

___ Learning Disability

___ Mobility Impairment

___ Head Injury

___ Psychological/Emotional

___ Upper Body/Extremities

___ Chronic Illness

___ Other (please specify) _____

Are you a client of:

Vocational Rehabilitation ___ Name of Counselor _____

Dept. of Veterans' Affairs ___ Name of Counselor _____

Name and address of High School or Health Care Professional: _____

Please describe how your disability affects your academic studies: _____

