

Assistive Technology Evaluation and Training Referral Form

Name: _____				
First	M.I.	Last		
S#: S _____		Phone #: _____		
Email: _____@student.cccs.edu				
Your official CCD email account is the only email CCD will accept for correspondence.				
<i>I affirm that I have read, understand, and agree to this form in its entirety and that the information supplied is true and complete.</i>				
Student: _____				
Print Name	Signature		Date	
Date: _____		CTE? <input type="radio"/> Yes <input type="radio"/> No		Major: _____
Enrolled Semester: _____		Accessibility Specialist Name/Phone: _____		
<i>Underline All That Apply:</i>	DEAF	BLIND	LOW VISION	ADD/ADHD
HEALTH ISSUES	LD	ORTHOPEDIC	MENTAL ILLNESS	TBI
In my opinion, the student struggles in the following areas (feel free to elaborate):				
Reading (decoding)				
Reading comprehension				
Writing skills				
Organizing thoughts				
Study habits				
Typing/Computer skills				
Focusing/Concentration				
Memory				
Expressing Thoughts x putting thoughts into phrases				
Other:				
Physical Accommodations needed in the AT Lab:				