SOLANO COMMUNITY COLLEGE
APPLICATION FOR ACCESSIBILITY SERVICES CENTER (ASC)

Academic Year **2024 -2025**

STUDENT MUST COMPLETE THIS BLOCK

Name: _____ SCCID: _____
Date of Birth: _____ **Gender: M** ☐ **F** ☐ **Decline to State** ☐
Address: _____
Telephones: (H) _____ (C) _____ (Other) _____
E-mail: _____
Are you a client of the Dept. of Rehabilitation? Yes ☐ **No** ☐

ASC Overview:

Solano Community College (SCC) provides educational services and access for eligible students with **documented disabilities** who intend to pursue coursework at *SCC*. A variety of programs and services are available which afford eligible students with disabilities the opportunity to participate fully in all aspects of college programs and activities through appropriate and (***reasonable accommodations)***. **Completion of this form constitutes an agreement to apply for services from ASC.**

Student Responsibilities: (Please read carefully)

1. I understand that I am required to provide the Accessibility Services Center with **written documentation** (ex: medical, educational, or psychological forms, etc. to verify my disability.
2. I will meet with a ASC staff person to complete my **Application for Services** and the **Accommodation Agreement Form (AAF)**. **I agree to meet with my counselor once per semester to discuss my progress in classes. I understand that I must also renew my Application for Services and the AAF Form *each fiscal year* for which I choose to utilize ASC Services.**
3. I will utilize ASC in a responsible manner, and understand that ASC has written policies and procedures that must be adhered to for continuation of services.
4. I will comply with the Student Code of Conduct adopted by the college. Initial

I understand that I must fulfill the requirements stated above for participation in ASC. I understand the consequences of failing to comply with the rules for responsible use of ASC services. I understand that I will be notified in writing before any action is taken to suspend services. By signing this application I affirm that I understand and agree with the ASC Program responsibilities of students, and I will abide by them.

_____ _____
Student Signature Date ASC Certificated Staff Signature Date

The 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 Accessibility Services Center. 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 93-579; 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.

ASC OFFICE USE ONLY

Primary Disability Categories

____ ABI ____ DHH ____ Mental Health ____ ADHD ____ Autism ____ Physical Disability

____ LD ____ ID ____ Blind and Low Vision ____ Other Health Conditions _____

For MIS Staff Use Only: → → → Summer ☐ _____ Fall ❒ _____ Spring ❒ _____