Disability Resources
2800 S. Lonetree Rd.
Flagstaff, AZ 86005
(928) 226-4323
1-800-350-7122 x4323
FAX (928) 226-4103

Disability Resources (DR)

Request for Support

Name (list any previous names if applicable) ____

Address: ____

City: __________________________ State: _____________ Zip: ____________________

Phone #: ______________________ Alternative Phone # ___________________________

Email: _________________________ Emergency Contact # _________________________

May we contact you via email regarding this request? _____ YES ____NO

Date of Birth _____/_____/_____ CCC ID#: _______________ Comet ID # ________________

Type of Disability:

____ Learning Disability/ADD
____ Physical Impairment
____ Visual Impairment
____ Medical (please specify) ______________
____ Hard of Hearing
____ Deaf
____ Blind
____ Psychological
____ Intellectual Disability
____ Autism
____ Other ____

Have you chosen a major? ____ YES ____ NO If yes, please list: ______________________

Have you ever attended CCC? ____ YES ____ NO
Have you ever applied for DR services? ____ YES ____ NO

When do you plan to attend CCC? FALL ☐ SPRING ☐ SUMMER ☐ For what year ________

Which CCC campus/site will you attend? ____
Are you currently or have you been a client of Vocational Rehabilitation - RSA)? ___YES ___NO

V.R. Counselor: __________________________ Location: __________________________

Parent(s)/Legal Guardian: ____
(Please print names in full)

I understand that I must meet with the Disability Resource Coordinator and provide current documentation of my disability in order to be eligible to receive accommodations. I certify that the above information is accurate and true to the best of my knowledge.

Student Signature: ____________________________________ Date: _____/_____/_____