THE MASTER'S
UNIVERSITY

Office of Disability Services Student Intake Form

Please submit the appropriate disability verification with this form.

PERSONAL INFORMATION (Please print clearly or attach typed document)

DATE: _____ TMU I.D. #_____

NAME: _____ RESIDENCE HALL: _____

ADDRESS: _____ PERSONAL EMAIL: _____

CITY: _____ STATE: _____ TMU EMAIL: _____

ZIP CODE : _____ CELL: _____

ACADEMIC STATUS

First Year_____ Second Year_____ Third Year_____ Fourth Year Other_____

Major program (if declared) _____

Are you a transfer student? NO_____ YES_____

The documentation I will submit verifies that I have the following disability: (Check all that apply)

- ☐ LEARNING DISABILITY
- ☐ ADHD (with or without hyper-activity)
- ☐ MOBILITY IMPAIRMENT
- ☐ AUTISM SPECTRUM
- ☐ TBI (Traumatic Brain Injury)
- ☐ SPEECH/COMMUNICATION
- ☐ DEAF/HARD OF HEARING
- ☐ BLIND/VISUAL
- ☐ PSYCHOLOGICAL _____
- ☐ CHRONIC HEALTH IMPAIRMENT _____
- ☐ OTHER _____

Briefly describe **YOUR** understanding of your current impairment and any relevant diagnosis.

_____

_____

_____

_____

_____

When were you first diagnosed with the condition you consider disabling? If more than one, list them separately?

_____

_____

_____

_____

_____

Describe how your condition(s) or impairment(s) impact your functioning in a university setting and any difficulties you are having.

What accommodations are you requesting at The Master's University?

Describe in detail the accommodations you have received in the past, including the nature of the accommodation(s), the name of the providing institutions, and dates provided.

When and by whom were you recently evaluated/treated for the condition(s) that cause your impairment?

A review of your documentation relating to your request will not be commenced until this form and all supporting documentation have been received. We do not review materials until your file is complete. Upon receipt of all documentation, your file will be reviewed, a process that typically takes no less than 14 days. **Please do not send original copies of documentation. We do not return materials once submitted.**

By signing below, you are initiating your request to be established as a student with a disability in accordance with federal and state regulations.

Signature of Student _____ Date _____

Mail, email or fax forms to:
Office of Disability Services, The Master's University
Attn: Kara Antariksa
21726 Placerita Canyon Road
Santa Clarita, CA 91321

Kantariksa@masters.edu
FAX: 661-362-2668

OFFICE USE ONLY

DATE INTAKE FORM REC'D _____

DS VERIFICATION _____

DOCS COMPLETE YES_____ NO_____

CONFIDENTIALITY AGREEMENT _____

OTHER _____