WENTWORTH INSTITUTE OF TECHNOLOGY

Center for Wellness and Disability Services
Disclosure Form

Complete this form and return to the Center for Wellness at Wentworth (see address below)

Name _____ Student I.D. Number _____

Date of Birth _____ Email address_____ Cell Phone (_____) _____ - _____

Address_____ City _____ State _____ Zip Code _____

Major _____ Expected Year & Semester of Enrollment_____

Select (at least) one of the following:

Learning Disability

___Math Related ___Reading Related ___Writing Related

___Other (please specify) _____

Physical Disability

___Hearing Related ___Vision Related ___Mobility Related

___Other (please specify) _____

Psychiatric Disability (including ADHD)

___Please specify_____

List any services and/or accommodations you would like to request.

Note: This is NOT a request for services. The answers you provide here are used for informational purposes only.

_____

_____

_____

_____

Additional Information

1. High School attended _____ Year of Graduation _____
2. Name of previous colleges attended (if any) _____ Years_____

I grant Wentworth Institute of Technology permission to use educational and medical records provided by me to the Center for Wellness and Disability Services.

_____ _____

Student Signature Date

Please note that it is <u>your</u> responsibility to obtain and send documentation to:

Wentworth Institute of Technology, Attn: Center for Wellness and Disability Services, 550 Huntington Ave, Boston, MA 02115
Phone: (617) 989-4390 Fax: (617) 989-4571