

Support Services Recommendations

To be completed by high school specialist (special education teacher or school psychologist). This information will assist a D.E.S.P. learning specialist evaluate and determine services at the college level.

Student's Name _____ Birth date _____

Date of IEP: From _____ To _____

This high school student is currently receiving the following accommodations based on their disability assessment.

Please check all that apply:

<input type="checkbox"/>	Registration Assistance
<input type="checkbox"/>	Test Accommodations:
<input type="checkbox"/>	Extended test time of ½ hour per hour
<input type="checkbox"/>	Extended test time of 1 hour per hour
<input type="checkbox"/>	Distraction reduced environment
<input type="checkbox"/>	Reader
<input type="checkbox"/>	Scribe
<input type="checkbox"/>	Computer
<input type="checkbox"/>	Text Reader:
<input type="checkbox"/>	E-Text
<input type="checkbox"/>	Texts on Tape (Certification)
<input type="checkbox"/>	Note Takers
<input type="checkbox"/>	Tutoring
<input type="checkbox"/>	Tape Record Classes
<input type="checkbox"/>	Spell Checker
<input type="checkbox"/>	Computer Adapted Technology

Other accommodations (Please specify):

High School Specialist's Signature _____ Date _____

Contact telephone # and/or e-mail address _____