College of Menominee Nation
Office of Disability Services
Needs Assessment Form
Semester:___________

Student Name:_________________________________________ ID #: __________________

Address:________________________________________________ Phone:________________

Documentation of disability on file? YES NO

DVR/VRNA/MVR Client? YES NO

If yes, counselor’s name:____________________________________

Description of primary disability/condition:
_____________________________________________________________________________________
_____________________________________________________________________________________

Medications:
_____________________________________________________________________________________
_____________________________________________________________________________________

Course Name(s) & Instructor(s):
_____________________________________________________________________________________

Classroom Accommodations: (circle) Record Lectures Taped Texts Scribe Tutoring

Copies of PowerPoints Sign Language Interpreter Not Taker Use of Calculator

Other:
_____________________________________________________________________________________
_____________________________________________________________________________________

Exam Accommodations:
___ Additional time (as needed; time and a half is appropriate for most exams)
___ Distraction free environment

___ Proctor Exams: (circle) Reader Scribe Computer Assistant Exams Calculator

___ No penalization for spelling on impromptu writing and essay questions (if accuracy of terms is
critical, have instructor meet with student after exam to clarify questions.)

___ Other: ____________________________________________________________

Student Signature & Date:__________________________________________

SAS/Advisor Signature & Date:_______________________________________