# University crest

# Disability Accommodation Request Form for Division of Extension

**Please return form to Heather Stelljes at McBurney Disability Resource Center by mail, fax, or or email at** [**heather.stelljes@wisc.edu**](mailto:heather.stelljes@wisc.edu)

To apply for accommodations for a UW-Division of Extension event or program, please complete and submit this form. If this form is not accessible for, please contact Heather. Additional documentation pertaining to your health condition(s) or disability may be required.

**Date Completed:** \_\_\_\_\_\_

# Participant Information

|  |  |
| --- | --- |
| **Name** | Last Name:       First Name:      Middle Initial:  Preferred Name:       Preferred Pronouns: |
| **Identification** | Date of Birth: |
| **Preferred Phone** | Phone #: |
| **Email** | Email:  Secondary Email: |
| **Local Address** | Address:  City:       State:       Zip code:  County: |

### If somebody other than the participant completes form, please share the following information:

|  |  |
| --- | --- |
| **Name and relationship to participant** |  |
| **Phone Number** |  |
| **Email** |  |

# ****Program or Event Information****

|  |  |
| --- | --- |
| **Name of Event or Program** |  |
| **Date(s) of event or program** |  |
| **Name of person organizing event or program (if known)** |  |
| **Phone number or email of person organizing event (if known)** |  |

## **Program Area**

|  |  |  |
| --- | --- | --- |
| Agriculture | Community Development | Family and Finance |
| Health | Natural Resources | Youth Development |
| Upham Woods | 4-H | Other: |

# Disability Information

**(If you are completing this form on behalf of the participant and are unsure of the nature of the condition, this section can be left blank)**

**Describe your health condition or disability and how it affects your ability to participate in the Division of Extension program or event:**

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| --- |
|  |

# Accommodation Information

**Describe any accommodations or services you are requesting and why:**

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**Describe any accommodations you received in the past that have provided access:**

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|  |

**Please list the name, specialty area, and phone number of all providers for whom you are currently under care or who diagnosed your condition:**

|  |
| --- |
|  |

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