TRAINING AND ADJUSTMENT SERVICES STUDENT APPLICATION

SERVICES FOR THE BLIND AND VISUALLY IMPAIRED

Part I. General Information

Date:		**Birth Date:**		**Gender**	**Male ☐** **Female ☐**
Full Name:				**Preferred Name:**	
Mailing Address:					
City:		**State:**		**Zip Code:**	
Permanent Address (if different):					
City:		**State:**		**Zip Code:**	
E-Mail Address:					
Home Phone Number:		**Cell Phone Number:**			
Utah Resident:	**Yes ☐** **No ☐**	**Height:**		**Weight:**	**Shoe Size:**
Do you have an open Rehabilitation Case?	**Yes ☐** **No ☐**	**Counselor's Name:**			
Primary source of income:	**Employment, Self ☐**	**Employment, Spouse ☐**	**SSI ☐**	**SSDI ☐**	**Other ☐**
Do you live alone, with family or other?	**Alone ☐**	**Family ☐**	**Room Mate(s) ☐**	**Care Center ☐**	**Other ☐**
Do you want to attend classes full or part time?	**Part Time ☐**	**Full time ☐**	**Full-time and Stay in Apartments ☐**		
What month would you prefer to begin your training?					
Cause of vision loss:					
Stability of vision:	**Stable at least 2 years ☐**	**Changing rapidly ☐**	**Changing Slowly ☐**	**Totally Blind ☐**	
Have you ever been convicted of a felony or misdemeanor crime? If yes, please explain below:	**Yes ☐** **No ☐**				
Explanation:					

Emergency Contact Information

Contact Name:	Telephone Number:	Relationship to You:

Describe your primary reason for choosing to seek training at this time?

How were you referred to TAS?	**Rehab Counselor ☐**	**Doctor ☐**	**Organization ☐**	**Friend ☐**	**Other ☐**
Name of referrer:			**Telephone Number:**		
Address:					
Have you attended (any) previous formal blindness skills training program?	**Yes ☐**	**No ☐**	**When:**		
Name of Program:			**City/State:**		

Part II Educational Background

What level of education are you at currently? What certifications, diplomas, or college degrees have you earned?

High School-Not completed ☐	High School Graduate ☐	GED ☐	Certification ☐	Some College ☐
Associate Degree ☐	Bachelor's Degree ☐	Master's Degree☐	Doctorate Degree ☐	Other ☐

Where did you last attend High School?				
Name of college or University you attended:				
Major Course of Study:		Dates Attended:	From:	To:
Name of college or University you attended:				
Major Course of Study:		Dates Attended:	From:	To:
Name of college or University you attended:				
Major Course of Study:		Dates Attended:	From:	To:

Part III Employment Background

Provide the company name, your position, when you worked there, and why you no longer work at your last 3 jobs:

Company Name:		Position:	
From:	To:	Reason for leaving:	
Company Name:		Position:	
From:	To:	Reason for leaving:	
Company Name:		Position:	
From:	To:	Reason for leaving:	

Part IV Medical Background

The training program is a highly physical, mental and emotional learning experience. Please check all of the following that apply to you, and describe any additional disabilities or concerns in detail where indicated. This will help us meet your individual needs:

Diabetes: ☐	Type:	One ☐	Two ☐	Insulin Dependent?	Yes ☐	No ☐	Neuropothy?	Yes ☐	No ☐

Hearing Loss: ☐	Right Ear ☐ Left Ear ☐	Wear hearing aids?	Yes ☐ No ☐	Do you use sign Language? Do you read lips?	Yes ☐ Yes ☐	No ☐ No ☐

Learning/Cognitive Processing: ☐	Traumatic Brain Injury (TBI): ☐	ADHD: ☐	Stroke: ☐	Demensia: ☐

Mental Illness: ☐	Seizures: ☐	Blood Pressure: ☐	Sleep Disorders: ☐	Asthma: ☐	Respitory Problem: ☐

Alergies: ☐	Specify:

Speech Disorder: ☐	Orthopedic/Back Problems: ☐	Kidney Problems: ☐	Past Alcohol/Substance Abuse: ☐

Psychological/Emotional Issues: ☐	Depression: ☐	Anxiety: ☐	Behavior: ☐	Other: ☐

Please use this space to provide additional details regarding any medical concerns you have:		
Are you familiar with safety skills such as accessing emergency services, understanding and complying with emergency evacuation procedures, managing first aid care on self, etc.? Yes☐ No ☐		
Name(s) of Medical Practitioner (Doctor):	**Telephone Number:**	
Preferred Hospital Name:	**Telephone Number:**	
Medical Insurance Provider(s):	**Membership Number(s):**	**Telephone Number:**
Are you able to manage your own health care and self-administer medications?	**Yes ☐**	**No ☐**
Current List of Medications continued:	**Dosage:**	**Frequency:**

Part V Additional Information And Requirements

What are your greatest strengths?
What are your greatest weaknesses?
What do you want to accomplish from this training experience?
What goals do you have for your future?
TAS requires a current (within two years) visual acuity (eye report) from an ophthalmologist for verification of legal blindness. TAS also requires a valid Utah Identification card.
I understand this is a non-visual training program and I will be required to wear training shades in order to keep a full-time or part-time status. Please sign your name to indicate that you are willing to abide by this requirement. Electronic signature is accepted.

Student Signature: _____

Visit our website at https://www.usor.utah.gov/dsbvi
Completed applications can be emailed to jodiduke@utah.gov, faxed to 801-323-4396, or mailed to 250 North 1950 West, Suite B, Salt Lake City, Utah 84116.